The Modern Hospital

JANUARY 1960

What It Takes To Conduct a Successful Fund Campaign

Who gives to fund drives, how to select professional counsel, and why some campaigns succeed where others fail are discussed in a special section (page 55)

Nurses Work Best at the Jobs They Like Best

Turnover and trouble can be reduced when nurses are assigned to the duties that match their skills and temperament (page 77)

Standardization Leads to Effective Food Management

The first article in a new series on modern food management technics tells why it pays to purchase food according to specifications (page 112)

Pediatrics playroom, St. Michael Hospital, Milwaukee (page 69)

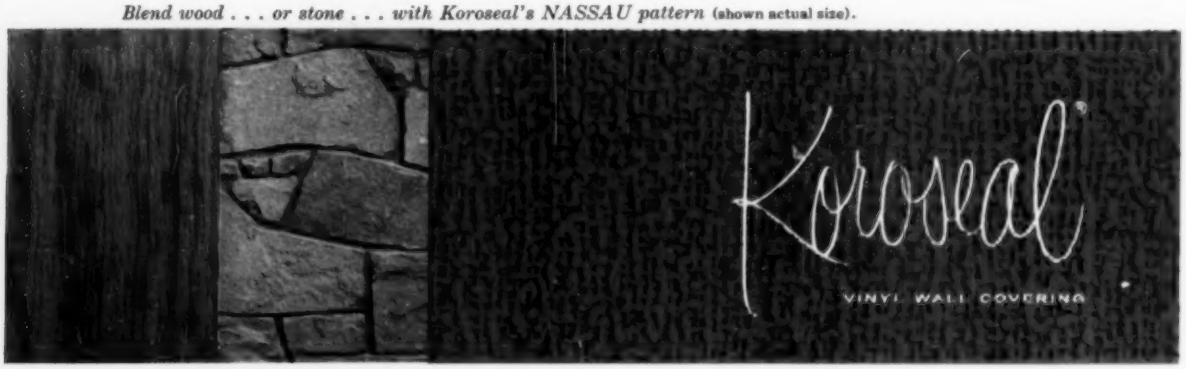
Reception area, Griswold-Eshleman Advertising, 55 Public Square, Cleveland 13, Ohio. Design by GF Studios.

For walls that are warm and practical . . .

blend Koroseal with natural materials

The reception area in this Cleveland advertising agency demonstrates how B.F.Goodrich Koroseal fabric-backed vinyl wall covering blends with natural materials such as stone and wood. Here Koroseal is used around elevator and seating areas where wear and tear are expected. Koroseal gives warmth to the area and is practical as well. It washes clean with soap and water, resists scuffs and stains, eliminates the need for periodic redecorating. See Koroseal's complete line of fire resistant wall covering and upholstery fabrics in Sweet's Architectural Catalog File No. 13k/Go. Or for swatches, write Department MH-2, *B.F.Goodrich Industrial Products Company, Marietta, Ohio.*

Blend wood . . . or stone . . . with Koroseal's NASSAU pattern (shown actual size).



B.F.Goodrich *Koroseal vinyl coated fabrics*

deliciously flavored • decisively effective

NEW ILOSONE® 125 Lauryl Sulfate SUSPENSION

Formula:

Each 5-cc. teaspoonful provides Ilosone Lauryl Sulfate equivalent to 125 mg. erythromycin base activity.

Usual Dosage:

10 to 25 pounds	5 mg. per pound of body weight	every six hours
25 to 50 pounds	1 teaspoonful	
Over 50 pounds	2 teaspoonfuls	

In more severe infections, these dosages may be doubled.

Supplied:

In bottles of 60 cc.

Ilosone® (propionyl erythromycin ester, Lilly)
Ilosone® Lauryl Sulfate (propionyl erythromycin ester lauryl sulfate, Lilly)

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The Modern Hospital

JANUARY 1960 VOLUME 94, NO. 1

Articles in this issue

Continued on next page ▶

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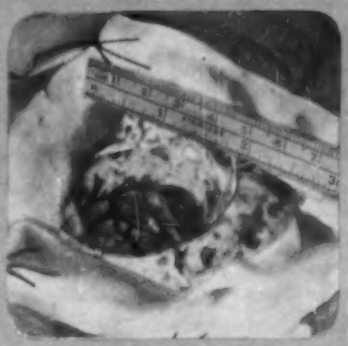
a new sound-color film...

"A new approach to the reduction of intracranial pressure with Urea-Invert sugar"



UREVERT™

(LYOPHILIZED UREA AND TRAVERT®)

TRAVENOL LABORATORIES, INC.

pharmaceutical products division of

BAXTER LABORATORIES, INC.

Morton Grove, Illinois

The clinical data presented in the film are taken from the case histories of more than 550 patients who received urea-invert sugar solution [UREVERT™] at the University of Wisconsin hospitals for a variety of cranial disorders.

The use of Urevert to facilitate intracranial surgery in glioblastoma multiforme, optic nerve glioma, fronto-temporal meningioma, cerebellar astrocytoma and retrogasserian rhizotomy is illustrated.

A comparison of Urevert with other hypertonic solutions demonstrates its superiority to such agents in reducing cerebrospinal fluid pressure and brain volume.

For Your Group—showing of this 19 minute film may be arranged by writing to Medical Film Library, Travenol Laboratories, Inc., Morton Grove, Illinois.

READER OPINION

Proprietary Hospitals and Nursing Homes Need Help

Sirs:

It is beyond belief that any profession would deliberately abandon a large segment of its field to the least qualified practitioners, yet that is precisely what hospital consultants and hospital architects have done in the case of proprietary hospitals.

Proprietary hospitals and nursing homes represent from one-quarter to one-third of all medical care facilities in the United States, yet our professional publications, qualified hospital architects, and the organized hospital field generally seem to treat them as something outside the pale.

It is not here intended to support proprietary hospitals as against the voluntary ones, but neither neglecting them, nor wishing them to do so will make them disappear. One suspects that so long as there is a profit to be made and private profit continues, so long will there be proprietary medical and nursing facilities.

Proprietary hospitals have in the past, with notable exceptions, failed to conform to even minimal standards. Communities had few, if any, regulatory norms. Of late there has been a slight change. Some larger cities had adopted codes which, with strict inspection and enforcement, should result in some improvement. Some privately operated hospitals, interested in advancing their status in a highly competitive field, have sought accreditation. This has had an uplifting effect. However, the requirements of both municipal codes and accrediting bodies are so minimal that the improvements have been quantitative rather than qualitative. There are bounds beyond which the unqualified planner cannot go. These bounds are mainly the lack of experience in planning voluntary facilities, the area in which most experimental work and most novelty of planning occurs. No one lacking experience in this field can be expected to bring to his work more than a limited, pedestrian approach.

Why then should not the reputable, experienced planners be working in the area of proprietaries? What, after all, is the great difference between proprietary and voluntary hospitals?

Anyone who has worked on both will testify that there is precious little difference between proprietary and voluntary hospitals. Each of our three main groups of hospitals has distinct characteristics, yet between the voluntary and proprietary the differences are so small, in the physical sense, that in a number of cases private hospitals have been taken over by charitable groups and vice versa, without change.

So long as proprietary hospitals are with us it behooves all those concerned with the maintenance of good hospital standards to extend their interest to the whole field. Should we continue to ignore the proprietaries the entire community must suffer the consequences. Not only will the private institutions continue to be relatively poorly planned, but by the immutable laws which govern such things, their low standards must ultimately infect the voluntary hospitals as well.

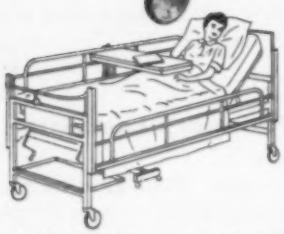
To maintain and continually elevate standards of all our medical care facilities it behooves all of us who are deeply concerned, whether in the planning

THE MANY-PURPOSE BED
THAT FILLS ALL YOUR NEEDS

HARD

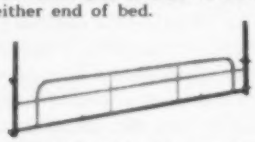
1484 RG

Here's the most versatile bed ever made for hospital use. Designed for recovery or intensive care areas, it serves a variety of other purposes as well.



Looks like a bed — not a piece of surgical apparatus. This tends to make the patient feel more "at home," more assured of recovery status.

27 x 12 x 1" storage tray is standard equipment. Adds to convenience particularly when moving patient from area to area. Attaches at either end of bed.



Hard's Slida-Side, the modern, space-saving, time-saving safety side is standard equipment.

Foot guard, Bucks Extension, Bierhoff Crutches, available as accessories.

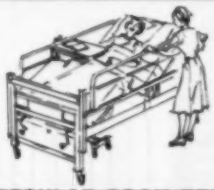
REALLY 6 BEDS IN ONE

EYE BED

Head piece removed. Bed permits access for eye work or other activities at the head area.

ORTHOPEDIC BED

When both head and foot pieces are removed, the bed will accommodate standard round tube overhead fracture frame for orthopedic use.



REGULAR ROOM BED

The bed is a handsome furniture piece that looks well in the standard modern hospital room, and works in conjunction with other hospital room furniture and equipment. HARD's 12-year guaranteed PG 16-position spring provides Trendelenberg, Fowler and Hyper-Extension as well as all standard treatment positions.

RECOVERY BED

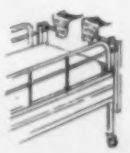
Bed is equipped with fittings for 1506PG Slida-Side Safety Sides which offer greatest possible protection, especially when bed is used for recovery. Large ball bearing casters make this an easy bed to move from Recovery or Intensive Care Areas to patient's room.

FRACTURE BED

With head or foot piece removed, end of bed is flush with mattress surface, allowing a direct pull at mattress level for traction with Bucks Extension.

DELIVERY BED

Bierhoff knee crutches quickly and easily installed at foot end for emergency deliveries.



THE HARD MANUFACTURING COMPANY

BUFFALO 7, NEW YORK – FOUNDED IN 1876

or administrative aspects, to give a fair share of consideration to the problems and standards of the proprietary facilities.

Isaiah Ehrlich
Architect

New York

Discussion Long Overdue

Sirs:

I thoroughly enjoyed the public relations articles by Gordon Davis in The MODERN HOSPITAL, and found intense satisfaction in his long overdue discussion of the proper place of the public relations director in the hospital hierarchy (October, page 12).

Throughout the full length of public relations seminars sponsored by the American Hospital Association, various aspects of this problem of being kept at arm's length keep coming up for discussion. It is revealed time and again that public relations directors do not get enough information on hospital operation and policy making to do an effective job – to say nothing of sitting in on policy making committees. The great majority of these people are capable, experienced and far-seeing, and yet must constantly struggle to get the working tools from the top. Most of these discussions at seminars finally end with the suggestion that the public relations person "sell" those who hired him to do an effective job.

Amid the cry for more efficiency in and streamlining of hospital operations – and economy – this constitutes such a sad waste of effort, time and money. With more emphasis being placed on the importance of good public relations in hospitals, and the demand for public relations people increasing in leaps and bounds outside the hospital field, with most attractive salaries attached thereto, it is felt that the time is more than ripe for hospital administrators to reevaluate this department "down the hall" and once and for all place it in its proper place in hospital organization.

Name Withheld

Pharmacy Committee Vital

Sirs:

Under "Small Hospital Questions" in your November issue, the role of the pharmacy committee in the control of hospital infections is dismissed rather quickly. At our 310 bed hospital, we found the pharmacy committee to be vital in the success of our infections committee.

We were fortunate in getting the infections committee into operation *before* a real problem could develop. We think part of our good record is due to the pharmacy committee's active part in the regulation of antibiotic usage in the hospital.

As ratified by the medical board, the pharmacy committee urged that *"vigorous efforts should be made to reduce to the minimum, consistent with good patient care, the use of antibiotics in the hospital, especially as prophylaxis."*

Since it was accepted that resistant strains of staphylococcus tend to develop with use of any antibiotic in time, the pharmacy committee further recommended that novobiocin be withheld from general use and "saved" for the emergence of staphylococcus resistant to other drugs.

Excellent cooperation from the medical staff has resulted and the pharmacist and the pharmacy committee have maintained guard over usage to reinforce the rulings.

John T. Foster
Assistant Administrator
Stamford Hospital
Stamford, Conn.

Sterilizing the Gut

actol
SOLUTION

the synergistic intestinal bactericide

It is impossible to sterilize the patient's gut in your office sterilizer, but intestinal antisepsis can be assured by administering Actol before and after surgery.

In vitro tests show Neomycin Sulfate and Polymyxin B Sulfate in combination exert a synergistic action from 2 to 10 times as effective against susceptible organisms as either antibiotic alone.*

Actol is *bactericidal* to both gram-positive and gram-negative organisms specifically associated with intestinal infections*—

Escherichia coli • Aerobacter aerogenes • Pseudomonas aeruginosa • Staphylococci • Enterococci • Streptococci • Proteus vulgaris • Shigella paradysenteriae • Shigella dysenteriae • Salmonella species.

After oral ingestion, 3% of the total intake is the largest amount of Neomycin demonstrated in the urine. The bulk of Actol is excreted in the feces, permitting effective bactericidal concentration in the intestines.*

Since systemic absorption is insignificant, Actol will not induce sensitivity reactions when used as indicated.

FORMULA:

Each teaspoonful (5 cc.) contains:

Neomycin Sulfate U.S.P. (Equivalent to 45.5 mg. Neomycin Base)	65 mg.
Polymyxin B Sulfate U.S.P.	5,000 units

*References available on request.

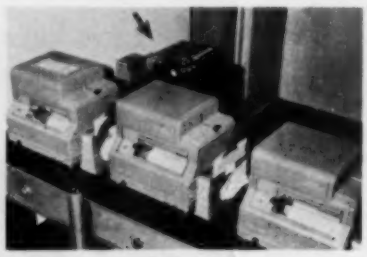
THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE
NEW YORK • KANSAS CITY • SAN FRANCISCO

ROVING REPORTER

Doctors Dictate Medical Records from Home or Office

Doctors at Baptist Memorial Hospital, San Antonio, Tex., can dictate medical records from their downtown offices, homes or wherever a telephone is available into the hospital's central recording system.

A doctor who wants to dictate merely dials the hospital switchboard and asks the operator to connect him with the dictating unit. This adds greatly to the convenience of dictating medical records.



These remote dictating units make it easy for staff to telephone records. Arrow points to the telephone which is attached to the dictating machine.

As one doctor states, "It saves me a tremendous amount of time as all histories on my patients are kept in my office and I no longer have to take my records to the hospital with the possibility of losing or misplacing them. I can now dictate from my office records without removing them from my desk."

Since September when this equipment was added, 35 doctors in the San Antonio area have used the service and have expressed their enthusiasm over the ease with which records are completed.

In 1955 Baptist Memorial was the first to install a system that made every telephone in the hospital a dictating unit. These units record, play-back, mark corrections and length of dictation.

The new remote dictating unit developed by a dictating and transcription company and the hospital engineers does not yet have all of these features. The play-back and correction marking devices are not yet available, but are under consideration and research. The lack of these two features has not proved a great problem in the transcriptions of the records to date.—DAVID GARRETT, *assistant administrator*, and ALICE WADE, *record librarian, Baptist Memorial Hospital, San Antonio, Tex.*

Taste Own Medicine

House staff doctors were treated to a taste of their own medicine—in this case, a therapeutic diet—by the department of dietetics at Hartford Hospital, Hartford, Conn.

The luncheon was served as part of the department's program aimed at giving a better understanding of the range of diets available to patients and at helping doctors to instruct patients in the diet to be followed at home.

Last year the house staff was served a low sodium diet. The meal this year is known as Step 4 in the ulcer diet world, and is the one given to hospital patients who are ready to go home. It consisted of top round beef ground, asparagus, noodles and peach tapioca pudding. A number of the doctors had seconds, according to Ann Rockwood, assistant director of dietetics in charge of therapeutic diets.

In conjunction with the luncheon there were exhibits of Steps 1, 2 and 3 of the ulcer diet, and of box lunches suitable for an ulcer patient to take to work.

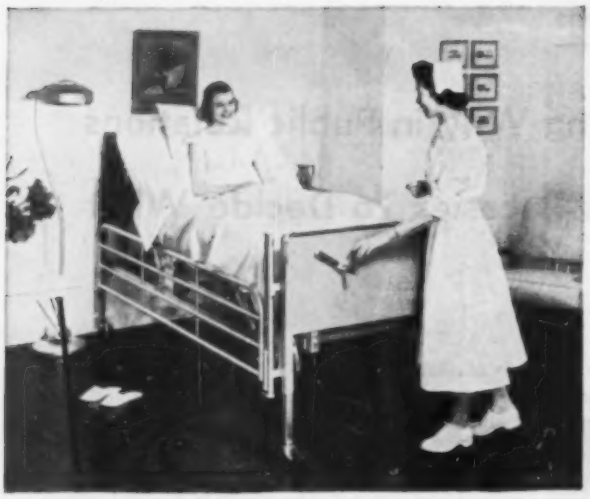
College Companions Help

Treatment of mental patients through companionship with college students is one of the new therapies being tried at Veterans Administration Hospital, Topeka, Kan.

Ten Washburn University students are participating. Each spends about two hours per week at the hospital with his assigned patient.

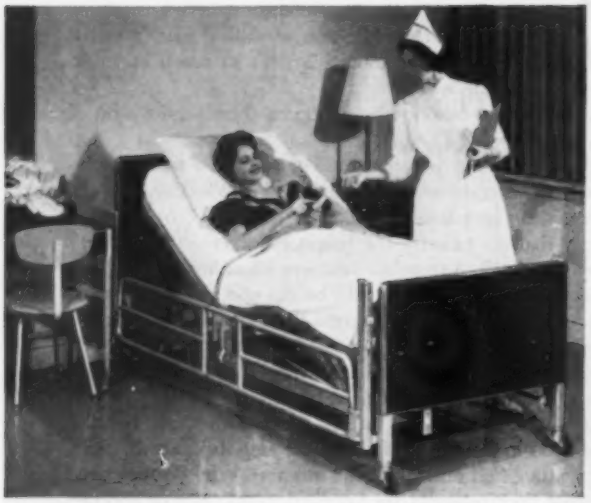
Companionship through activities is the basis of the program. All facilities at the hospital may be used by the youthful volunteers and the patients assigned to them. Activities include playing cards, bowling, swimming, bicycle riding, shopwork and others.

"We chose college students because they are youthful, energetic and vigorous," Dr. R. G. St. Pierre, hospital manager, says.



Popular manual Vari-Hite bed, No. H-914-3-L-226.

Versatile, easy-to-use Simmons Uni-Traction®



Sim-Matic bed gives nurse or patient finger-tip control of *all* bed positions; H-957-33-L-218.

Versatile recovery-eye-labor bed. No. H-918-3-L-162; HX-133 safety sides; HX-120 end guard rails.

Best patient care starts here

Because patient care centers around them, beds become the most important equipment you provide. Naturally, then, as you strive to provide the best in patient care, shouldn't you always consider the best in beds?

Simmons satisfies this requirement as does no other bed manufacturer. Every type of bed is available from Simmons—from completely motorized to fixed-position beds and dormitory beds. Whatever the need, there's a Simmons bed to fill it.

Simmons meets another important requirement—functional beauty. To achieve a pleasant, homelike room, Simmons beds feature attractive design and colorful styling. They are comfortable to live with. Equipped with Hospital Beautyrest* or Patient-Proof* mattresses, Simmons beds are also superbly comfortable to rest on.

Simmons' long experience, constant research, and continuing assistance from medical and hospital authorities make these best-bed advantages possible. So, equip with Simmons to assure your patients of the best in care.

*Trade-Mark Reg. U.S. Patent Office

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Public Relations

Knowing Why in Public Relations Makes It Easier To Decide What

By Gordon Davis

WANT to gain a reputation as a needler? Want to cause people to stir nervously when you enter the room?

Gordon Davis

It's easy. Simply start asking the blunt question, "Why?"

On the other hand, it isn't absolutely necessary to be blunt about it. The ability to find out why without arousing antagonisms — indeed, in such a manner as to stimulate constructive action — is one of the hallmarks of skillful management.

When you know why, it's so much easier to decide what.

In public relations as in everything human, there's quite a bit of what, but blessed little why.

Why, for example does your hospital or any other issue an employe publication, a news release, an annual report? Why do you make speeches or arrange an open house?

Don't reply that it's to carry the hospital story to others. That's not nearly precise enough. Any public relations effort involves a whole series of decisions, each of which should be the end result of specific reasoning. The matter needs to be thought through in advance, right down to the color of the paper used.

Example? Let's analyze some of the why's of the annual report, a communique of current concern to many hospitals.

Why issue an annual report in the first place? Obviously, because certain people need to be informed about the activities, needs, progress, present position, and outlook of the hospital. Why do they need to know? Because their interests are involved in one way or another. Why are their interests involved?

Ah, this is where we begin to get to specifics!

The interests of your trustees are quite different from those of your employes, from those of your community in general. The trustee fills a position of public trust. He needs a detailed statistical and factual report on the operations of the institution he is helping to guide.

The employe needs general understanding of the broad activity of which he is a part, reassurance as to his own future in this activtity, stimulus to better personal performance, a peg on which to hang his loyalty. The community needs to know that one of its most important resources is faring well or poorly, and what kind of community support is needed to assure future good performance.

So why do we see omnibus annual reports trying to cover all these diverse interests within one cover? Why do we see so many widely distributed reports containing detailed balance sheets and operating statements understandable to only a handful of persons? Why do we see expensively printed typographical dumping grounds for all accumulated information about a hospital, when a mimeographed report might serve the needs of trustees, a simple leaflet the interests of employes, and a news release the needs of the community?

To ask why, to keep on asking it until there are no why's left, to do so with the purpose of developing action rather than inaction, is to build constructively in public relations. Just for a starter, try the application of such a benign inquisition to your next annual report. ■

GET HANDS AS GERM FREE AS HANDS CAN BE WITH HEXA-GERM

ANTISEPTIC SKIN DETERGENT WITH HEXACHLOROPHENE

Statistics tell us that, in about 30% of all operations, surgical gloves break or are cut. Surgically clean hands are vital. This is one of the reasons so many hospitals use Hexa-Germ—a white, viscous, liquid antiseptic skin detergent with 3% hexachlorophene.

Tests show that routine use of Hexa-Germ degerms skin to a degree approaching sterility. It has also been proved effective in preventing staphylococcal skin infections in the newborn nursery. Because Hexa-Germ is blended with lanolin and petrolatum, it replaces the natural emollients lost through prolonged cleansing.

A special preservative in Hexa-Germ is highly active against all kinds of bacteria, including Gram negative microorganisms. This preservative protects Hexa-Germ against contamination that can result in handling, from the shipping containers to the dispenser jars, with a wide margin of safety. See our representative, the Man Behind the Huntington Drum, for full details and send for the Hexa-Germ Research Bulletin to get annotated test results.

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quality you can't wash out . . .
and they last longer!

It's remarkable what strong detergents and hard wear *can't do* to White Knight linens. Even after long service they are still "patient presentable" — the true measure of a quality hospital product!

Yet, this is a moderately priced line. And, a complete line. Sheets, blankets, spreads, towels, face cloths — just a sampling of the many guaranteed products quality marked with the White Knight label. Ask your Will Ross, Inc., representative to show you all of them.

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outstanding performance... and welcome economy

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Conforms to U. S. Pharmacopeia requirements when diluted as directed. Excellent lathering and rinsing qualities.

Remains clear even at low temperatures . . . does not develop a rancid odor on aging. Works in hard or soft water. Gentle enough for facial use.

Available in 1-gal. cans, 5-gal. pails and 30-gal. and 55-gal. drums.

COLGATE

Coleo Laboratory Glassware and Surgical Instrument Cleaner

Specially formulated to clean all kinds of glassware, instruments, rubber, plastic and enamelware in hospitals and clinical and industrial laboratories. *Easy on the hands*, Coleo dissolves readily—cleans thoroughly—rinses freely. Highly efficient blood-removal action.

Available in 5-lb. cans (6 to the case) and in 50-lb. and 100-lb. drums.

Because cleanliness is so vital in the hospital field, more and more hospitals look to Colgate for cleanliness maintenance products. Our technical staff is ready to help with your soap and detergent problems.

COLGATE **BEAUTY WHITE**

Made especially for hospital use. Hard milled for utmost economy. Lathers abundantly in hard or soft water. Your patients will enjoy its pleasing fragrance.

Available unwrapped in 3 sizes.

CP

COLGATE-PALMOLIVE CO. QUALITY PRODUCTS SINCE 1806 A SYMBOL OF QUALITY FOR OVER [illegible] YEARS

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There is a difference

It's difficult to distinguish between the Monarch butterfly (on the left) and the almost identical Viceroy. Yet the Monarch, because it secretes a fluid which is distasteful to birds, is therefore immune from their attacks — while the Viceroy depends only on its resemblance to the Monarch to keep from being eaten.

Because all brands of medical gases *look* very much alike, the differences between them are sometimes overlooked. Ohio Chemical, for example, insures extra-high purity for its gases by carefully controlling all stages of their production . . . from raw material inspection through processing and filling into rechecked, clean and freshly painted cylinders. Wherever you buy Ohio labeled medical gases, you can be sure they *exceed* U.S.P. requirements. This important difference is recognized and appreciated by the men and women who daily must administer these drugs with unquestioning confidence.

Ohio's colorful 24-page brochure on MEDICAL GASES is yours for the asking. Please write Dept. MH-1 requesting Form No. 4662.

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Serving the medical profession for fifty years
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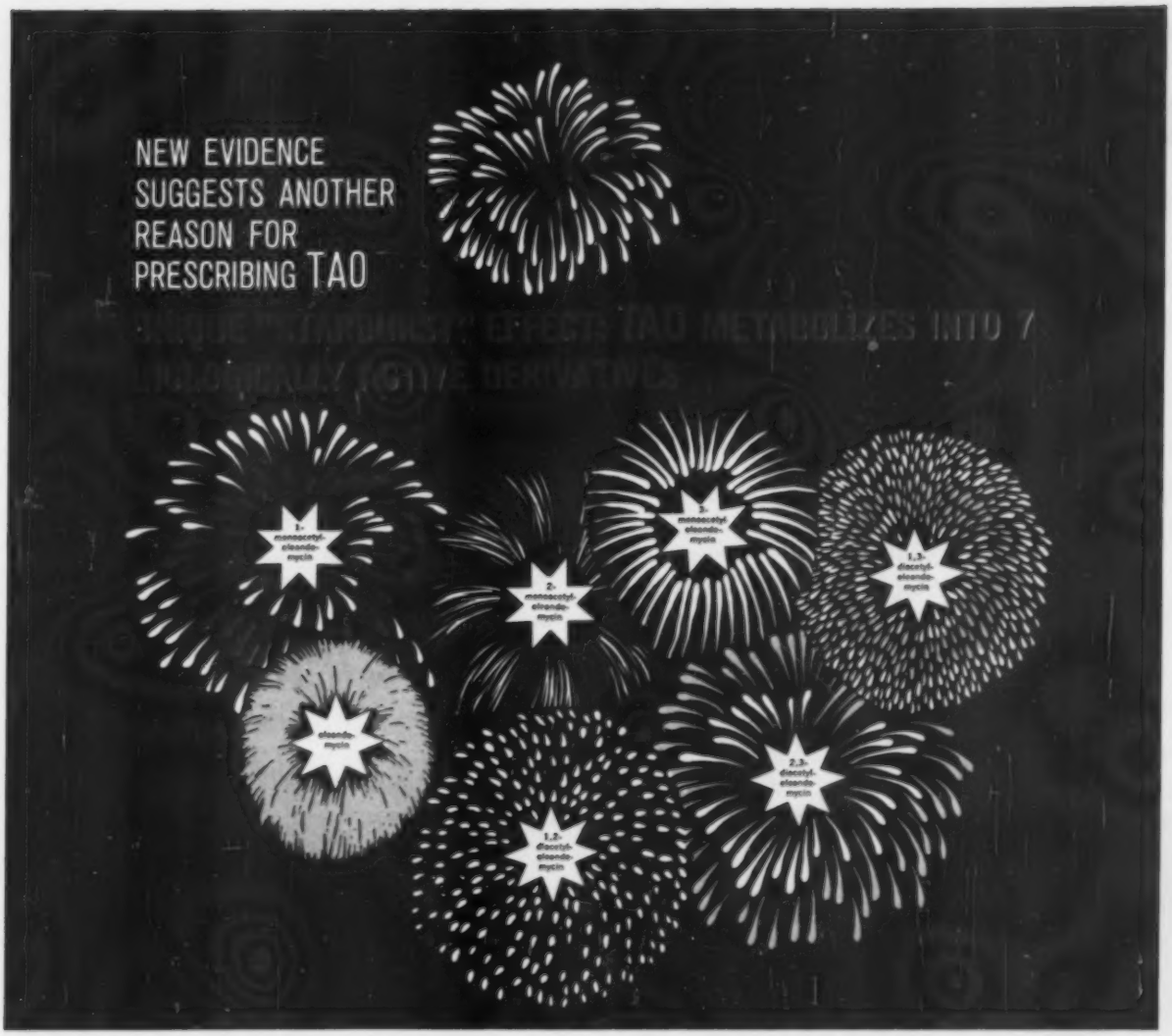


The impression that TAO is an unusually active antibiotic has steadily gained recognition by impressive clinical performance. Now come reports of in vivo and in vitro biological and biochemical evaluations that show TAO to be indeed unique.[1,2]

TAO differs from other antibiotics in that it is metabolized to multiple active compounds which remain active throughout their presence in the body. These 7 derivatives (in addition to TAO) show activity against common Gram-positive pathogens, including resistant strains of Staph. aureus.

In light of these findings, take another look at TAO performance: • 92% success in published cases of Gram-positive respiratory, skin, soft tissue and genitourinary infection • Effective against 78% of 64 "antibiotic-resistant" epidemic staphylococci. (In the same study, chloramphenicol was active against 52%; erythromycin against only 25%)[3] • No side effects in 94%; infrequent reactions mild and easily reversed • Quickly absorbed • Highly palatable.

Sound reasons to: Start with TAO to end 9 out of 10 common Gram-positive infections.

Supplied: TAO Capsules—250 mg., and 125 mg., bottles of 60. **TAO for Oral Suspension**—125 mg. per tsp. (5 cc.) when reconstituted; unusually palatable cherry flavor; 60 cc. bottle. **Prescription only.**

Other TAO forms available: TAO Pediatric Drops: flavorful, easy to administer. TAO®-AC: TAO analgesic, antihistaminic compound. TAOMID®: TAO with triple sulfas. Intramuscular or Intravenous: in clinical emergencies. Prescription only.

1. English, A. R., and McBride, T. J.: Proc. Soc. Exper. Biol. & Med. 100:880 (Apr.) 1959. 2. Celmer, W. D.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 277. 3. English, A. R., and Fink, F. C.: Antibiotics & Chemother. 8:420 (Aug.) 1958.

designed for superior control of common Gram-positive infections

Tao®

(triacetyloleandomycin)
Capsules/Oral Suspension

Roerig

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

NATIONAL PACKAGING AWARD WON BY ETHICON...

New York, November 17, 1959 – The 1959 Packaging Institute Corporate Award for outstanding advancement in applied packaging was presented to ETHICON, INC. during the Institute's 21st Annual Forum. The award was made for the new ETHICON Foil Suture Packet, developed after a decade of research for use with Electron Beam Sterilization. The packaging and Electron Beam Sterilization processes were conducted at the ETHICON laboratories in Somerville, New Jersey.

During the development of the award-winning suture packet, extensive clinical evaluations were carried out in hospitals throughout the country. Surgeons and operating room nurses participated in these evaluations which were designed to find out how well the foil packet performed under standard in-use conditions. Evaluating surgeons and nurses agreed overwhelmingly that the Foil Suture Packet best fills the exacting needs of operating room personnel and meets all operating room sterility requirements. Electron Beam Sterilized ETHICON Sutures in the new foil packet are now available at authorized ETHICON surgical distributors throughout the country.

Charles W. Kaufman (left), President of the Packaging Institute presenting the 1959 CORPORATE AWARD to Howard F. Zoller, Vice-President of the Ethicon Product Development Division (right).

...NEW FOIL SUTURE PACKET

easiest to use– just tear open

Electron beam sterilized and stored in formaldehyde solution— no change in operating room handling technique

ETHICON®

NEW
ROYAL
construction
concept
gives
you...

CUSTOM ARRANGEMENTS WITH MODULAR FURNITURE UNITS

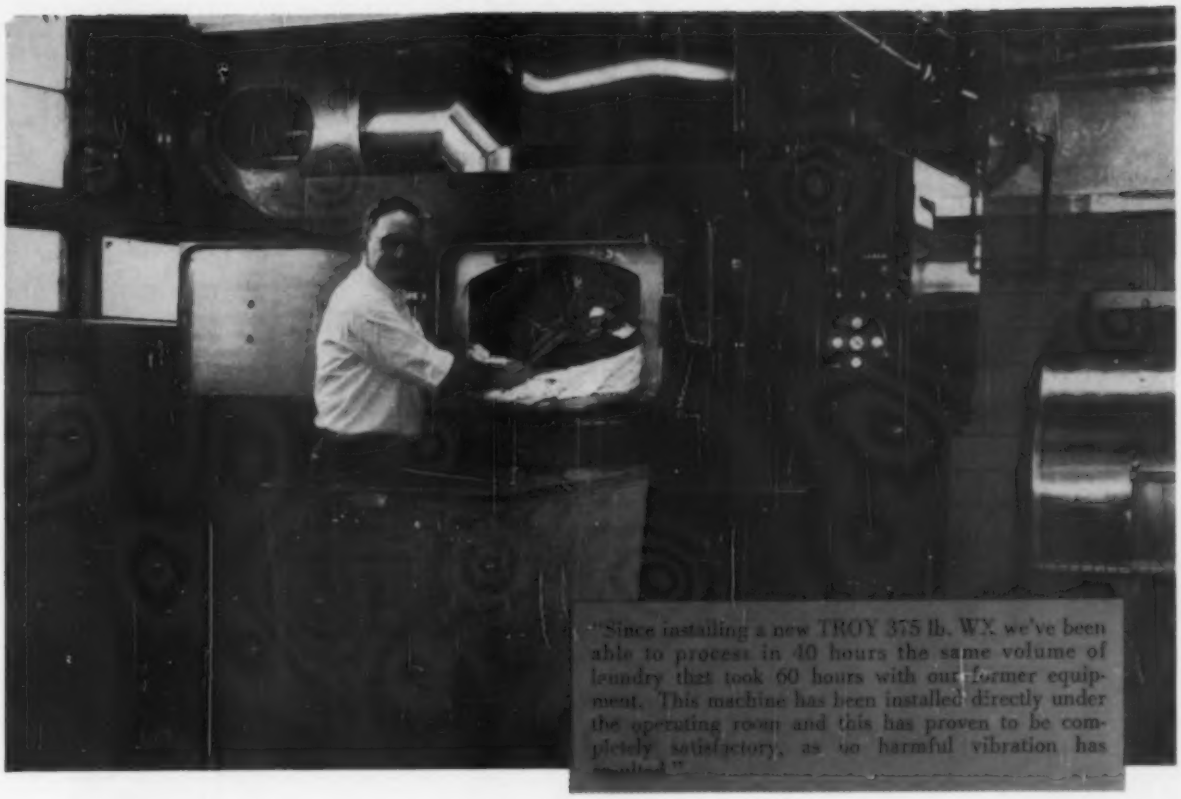
This new Royal VISCOUNT Modular Furniture is superbly functional. It's timelessly styled, meticulously made . . . and designed for infinitely variable arrangements as modular groupings and free-standing occasional pieces. Each unit is complete in itself . . . no complicated parts to order and assemble jigsaw-fashion.

VISCOUNT offers you more than 50 exciting new upholstery patterns and colors . . . from durable, wipe-clean materials to luxurious deep-textured fabrics. Impervious Royaloid table tops are available in 20 colors, patterns and finishes — from rich wood-grains and marbles to soft decorator pastels. And, one-piece leg-frames are of square-tube Satin Chrome finish.

Write for Royal VISCOUNT brochure 9026 for details
ROYAL METAL MANUFACTURING COMPANY
One Park Avenue, New York 16, Dept. 8-A

Assembly couldn't be simpler! Two hidden bolts join starter and add-on frames into rigid, unified ensembles. Seat-and-back sections clamp to frame at front and back. Table-tops and seats . . . can be interchanged in seconds . . . or frame assembly rearranged at will. Free-standing units for occasional chairs, tables, ottomans.

Royal VISCOUNT MODULAR FURNITURE



"Laundry Processing Time Cut 33⅓%"

. . . SAYS SIG. PAULSON, FAIRVIEW HOSPITAL, MINNEAPOLIS, MINN.

Check into these outstanding features of the new TROY WX WASHER-EXTRACTOR . . . features that have won the unqualified approval of the men who use them.

BIFURCATOR®—Exclusive! Fast, efficient cooling, conditioning and shakeout of linens; provides easier unloading. Linens ready for ironing upon removal from TROY WX WASHER-EXTRACTOR.

SPRAY RINSE FEATURES — Trunnion-type spray rinse provides faster, more efficient rinsing; shorter washing cycles; better quality. Less tensile strength loss.

FAST CYCLE FEATURES — Chart-type controls automatically put the TROY WX through all wash and extract cycles in less time than required for washing only on previous equipment. Flexibility of control provides repeat of cycles for extreme conditions, more reversals per minute — all controls conveniently located.

TROY BONUS QUALITY FEATURES — Complete safety features, ⅝" front shell plate, intermediate and high extraction speeds, stainless steel cylinder and shell sheets, heavy, durable shell door latch, perforated stainless steel partitions, stainless steel shell door, stainless steel lined front and rear shell plates, all V-belt drive — no chains or gears.

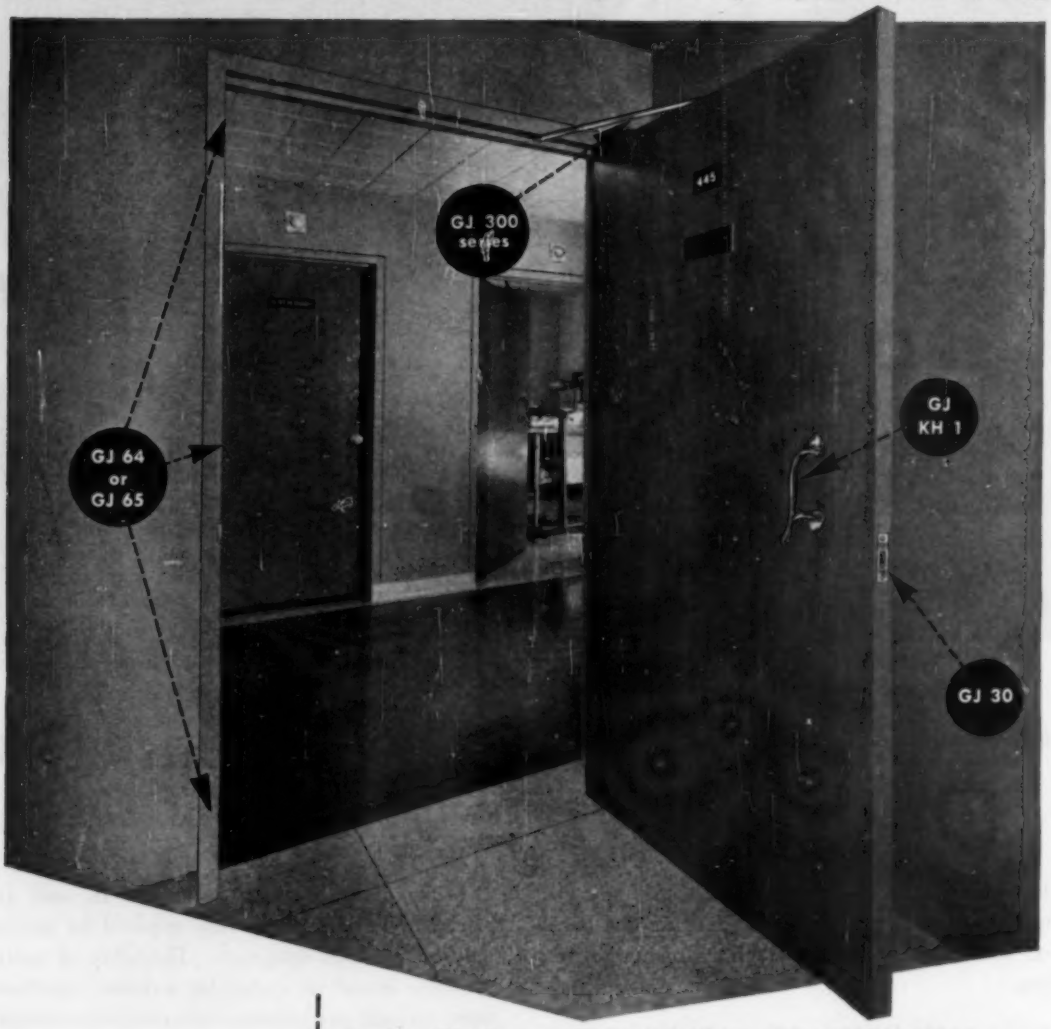
Troy® WX™ WASHER-EXTRACTOR
100 Lbs. • 200 Lbs. • 375 Lbs.

Write Dept. MH-160 for detailed bulletin

LAUNDRY MACHINERY
***Division of* American Machine and Metals, Inc.**
EAST MOLINE, ILLINOIS

For additional information, use postcard facing Cover 3.

an ideal specification for silent, efficient
PATIENT ROOM DOOR CONTROL



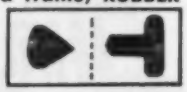
"shall have GLYNN·JOHNSON . . .

GJ 300 series CONCEALED (or surface mounted) OVERHEAD FRICTION TYPE DOOR HOLDER." (Nurse may set door at any desired degree of opening for ventilation or privacy. Door cannot slam open or shut.)

"GJ KH 1 COMBINATION HAND AND ARM PULLS to be mounted back to back as a pair." (Convenient for opening door from either side with sterile hands or when carrying loaded trays.)

"GJ 30 ROLLER LATCH." (Eliminates disturbing latch "clicking" sound. Replaceable rubber roller *silently* engages dirt-free strike. Latching pressure adjustable.)

"THREE GJ 64 for metal frame (or GJ 65 for wood frame) RUBBER SILENCERS." (Form pneumatic air pockets to absorb shock or noise of closing and create constant latch tension . . . no door rattling.)



This ideal specification for patient room doors is used in such outstanding hospitals as:

Kaiser Foundation Hospital, Los Angeles, Calif. Wolff & Philips, Portland, Oregon — architects

Oak Park Hospital, Oak Park, Illinois Shaw, Metz and Dolio, Chicago — architects

Providence Hospital, Washington, D.C. Faulkner, Kingsbury & Stenhouse, Washington, D.C. — architects

Rhode Island Hospital, Providence, R. I. Shepley Bulfinch Richardson & Abbott, Boston, Mass. — architects

All above hardware can be quickly installed on existing patient room doors.

write for HOSPITAL DOOR CONTROL brochure E-4

GLYNN·JOHNSON CORPORATION

4422 n. ravenswood ave. chicago 40, illinois

Light
for the surgeon's highest skill

DV-22E *A new and significant advance in the dual video concept*

The probing integrity of Amsco's surgical lighting research . . . which originated the now-routine dual video concept . . . currently validates still further advances of significant benefit to the surgeon, his patient and the operating team.

new **"Lumitrol" filter absorbs heat-producing infra-red rays and transmits natural, color-corrected light of the highest surgical quality yet attained.**

new **9-foot extruded aluminum twin tracks for maximal coverage of the operating table . . . are ceiling mounted and designed to minimize dust dispersal.**

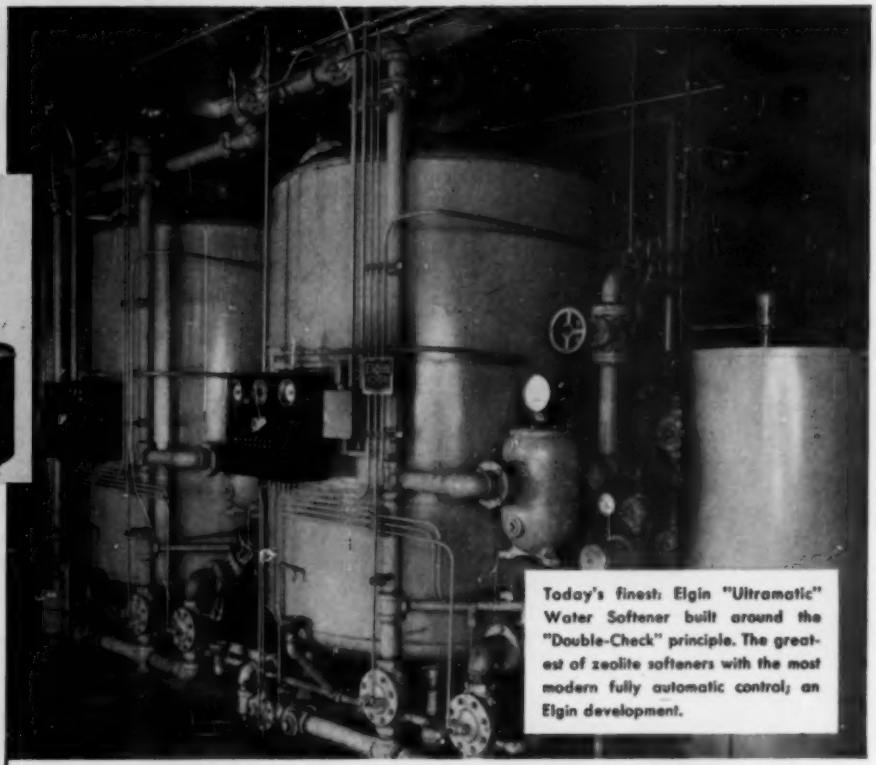
new **Lightweight "Rotoflex" arms increase "head space" around the table; permit circulating personnel to position lights in all planes, easily and accurately. ("Pinpoint" positioning by the surgeon himself continues to be accomplished with the patented sterilizable handle centered in the light beam.)**

Soundly engineered and manufactured with traditional Amsco precision, the DV-22E adds sturdy dependability and flawless function in further support of the surgical team.

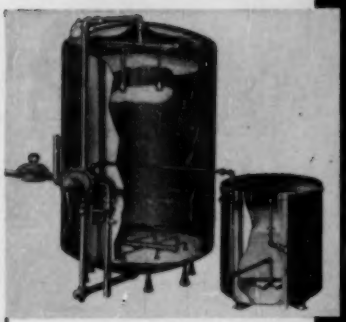
Write for technical bulletin LC-165.

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

World's largest designer and manufacturer of Sterilizers, Surgical Tables, Lights and Related Equipment



Today's finest: Elgin "Ultramatic" Water Softener built around the "Double-Check" principle. The greatest of zeolite softeners with the most modern fully automatic control; an Elgin development.



Only "Double-Check" gives you 44% more softened water

Some people think they can have "double-check" performance without using the "double-check" softener, but Elgin "Double-Check" users know better! This exclusive Elgin principle assures them up to 44% more soft water per regeneration from a softener of given size . . . prevents loss of zeolite . . . saves salt. Three types of control: manual multiport as illustrated above, automatic multiport, and "ultramatic" as in large illustration.

Dealkalizers

prevent corrosion of steam condensate return lines and equipment.

Deionizers

produce mineral free water equivalent to distilled water for most hospital uses—but produced at a fraction of distillation cost.

Deaerating Heaters

supply dollar-saving pre-heated boiler water, free of corrosive CO_2.

- Elgin services also include modernizing existing softeners, often with almost incredible gains in soft water output. Our representative will survey possibilities without cost or obligation.

Modernizing?

Don't overlook water conditioning!

There are two kinds of hospital modernization: the glamour kind and the basic kind. Glamour has its place, but never let it override the basic equipment that writes the real story of operating efficiency and profits.

There is no better example of basic equipment essential to every modernization or expansion program than the Elgin equipment illustrated and described here: The Elgin "Double Check" Water Softener with its unduplicated advantages. Elgin Dealkalizers to protect condensate piping. Elgin Deionizers to supply chemically pure water at a fraction of the cost of distillation. Elgin Deaerating Heaters to cut fuel costs and prevent corrosion.

Yes, while you're modernizing, modernize all the way through with Elgin equipment. Read the facts about Elgin equipment and services opposite. Ask for bulletin covering Elgin's longer and broader experience, or better still let us put you in touch with your local Elgin representative.

ELGIN
WATER CONDITIONING
SINCE 1908

ELGIN SOFTENER CORPORATION

144 No. Grove Ave., Elgin, Illinois

Representatives in principal cities
In Canada: G. F. Sterne & Sons Ltd., Brantford

CLEAN AND DESTROY BACTERIA IN ONE STEP WITH NEW DI-CROBE GERMICIDAL CLEANER

For the first time, a soapless anionic detergent and a phenolic germicide have been successfully combined. Di-Crobe Germicidal Cleaner cleans, disinfects and deodorizes most hospital surfaces in one easy step.

Di-Crobe is bactericidal under use dilutions. Quick-cleaning action and germicidal power remain stable, even when exposed to heavy soil. Hard or cold water may be used without fear of creating a soap film or of destroying conductivity.

Di-Crobe kills a broad spectrum of microbes, including resistant Staph, at very high dilutions. When not rinsed, Di-Crobe leaves a lasting antibacterial blanket. It is also non-toxic and non-irritating. See our representative, the Man Behind the Huntington Drum, for full details and send for the Di-Crobe Germicidal Cleaner Research Bulletin to get annotated test results.

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Henry R. W. Knudsen (left), Board Chairman, Superior Memorial Hospital, receives Lay Leadership Award of Honor from Douglas G. Burrill, President, Burrill, Inc., fund-raising counsel. If you are considering a fund-raising campaign, you are invited to call Mr. Knudsen collect at EXport 2-2283, Superior, Wisc. for recommendations. (Phone charges will be paid by Burrill, Inc.)

Raises $1,200,000 for Superior, Wisc. Hospital

Goes $450,000 over goal of $750,000 . . . proof again that Burrill fund-raising programs consistently meet and beat established goals.

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Burrill will make the same kind of survey, analyze the results, and submit recommendations to you—absolutely free! So . . .

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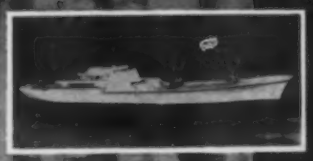

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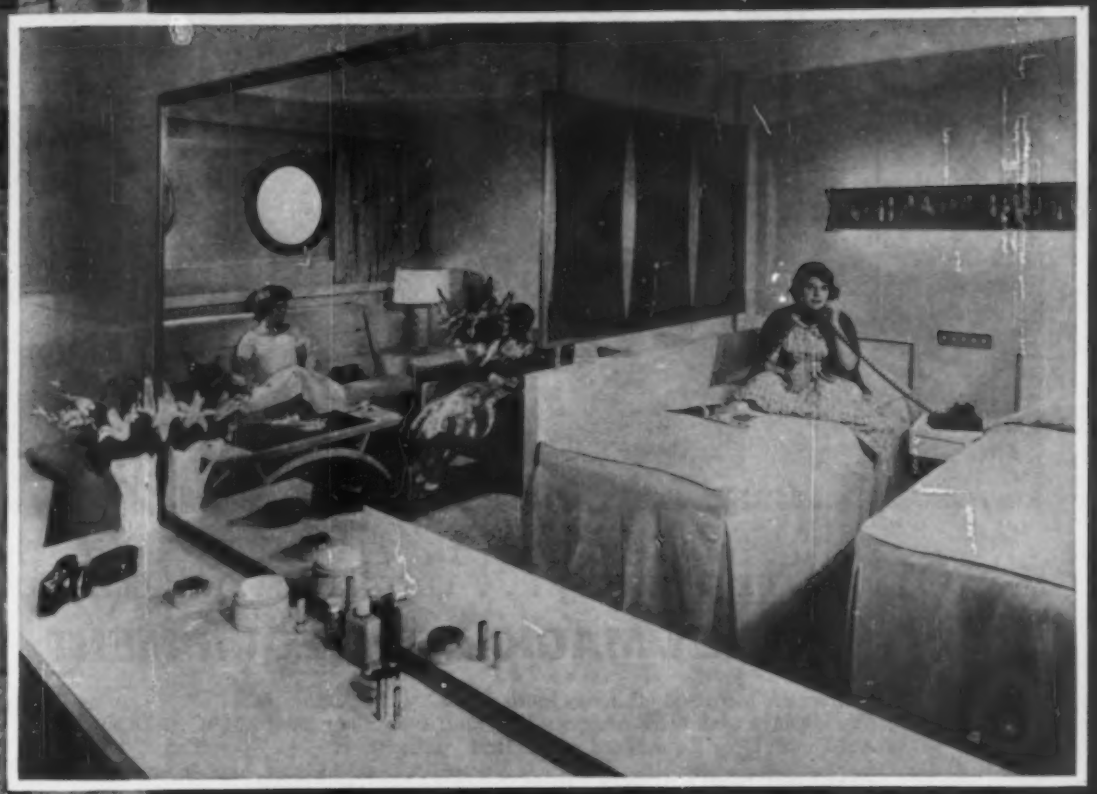

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The unique properties of Saranspun made it the logical choice for the world's first nuclear-powered ship. Soft as it is to the touch, Saranspun is amazingly rugged—withstands scuffing and beating without showing signs of abuse. It is inherently and permanently flameproof and is unaffected by moisture. Saranspun yarns are made of 80% solution-dyed saran fibers and 20% solution-dyed viscose – a blend that assures greatest fade-resistance. Saranspun means maintenance-economy in every type of commercial and industrial installation.

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". . . the Dyna-Pak is easy to operate, imparts a smoother finish to the garments and greatly reduces drying time which makes it possible for us to put out more work. With Dyna-Pak's very few moving parts maintenance is also easy, our Chief Engineer informs me."

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Years ago, the hardest working part of a mopping outfit was the moppers' knees. Couldn't do much about changing *their* design but the bucket and what passed for a wringer were ripe for improvement.

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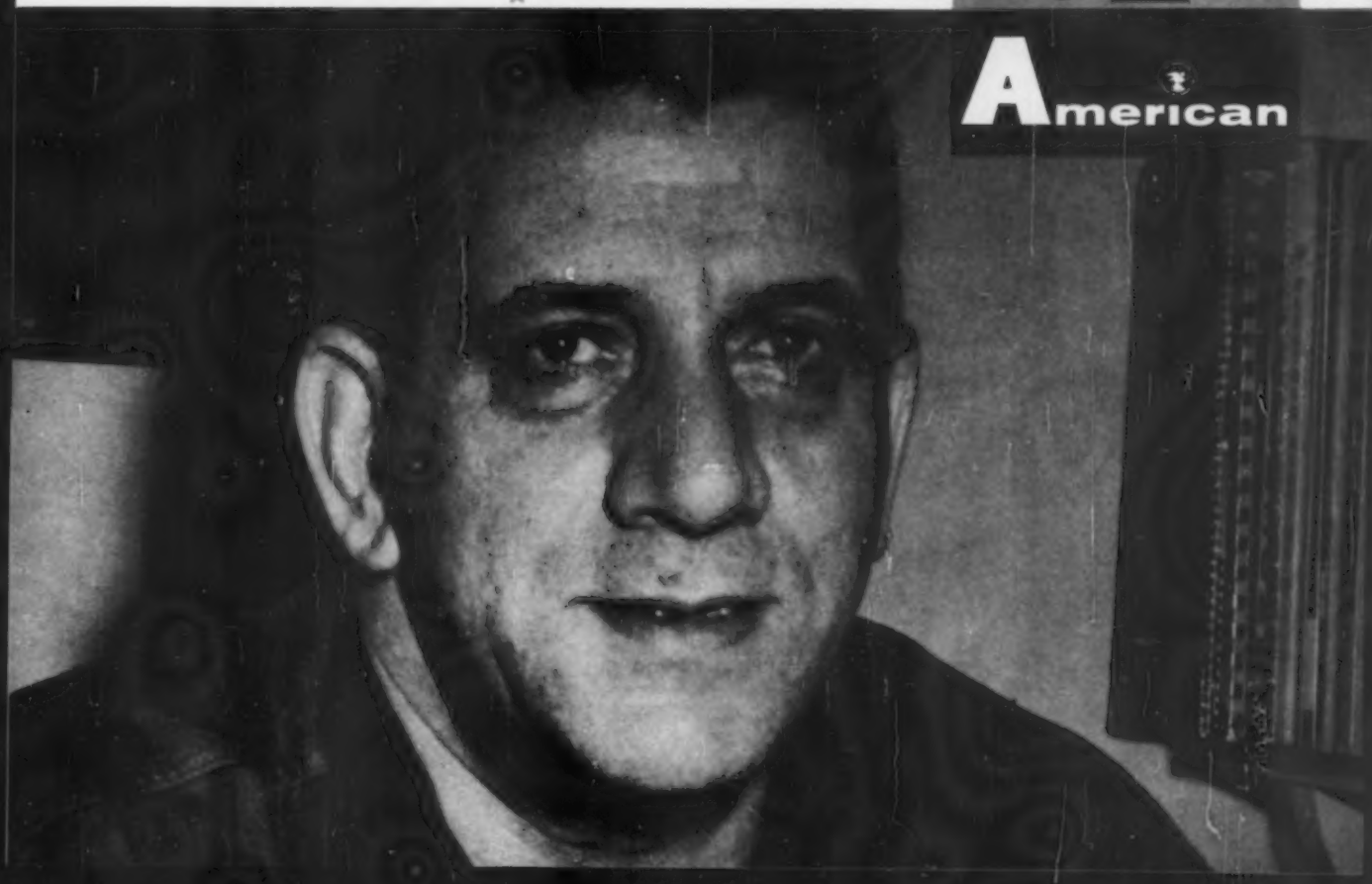
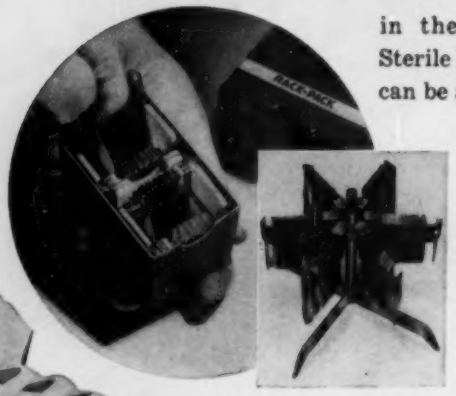


An EDGE on them all

Cutting efficiency and maximum blade performance has always been the surgeon's first consideration when choosing a surgical blade. BARD-PARKER offers you a blade made with the same consideration in mind . . . a blade of *carbon steel* of course . . . so superior for *fine cutting edges.*

B-P RIB-BACK Blades are now available . . .

in the Puncture Proof Sterile Blade package that can be autoclaved.



in the RACK-PACK package—blades pre-racked ready for sterilization.

in the CONVENTIONAL package—six of one size in a rust-proof wrapper.

It's Sharp

Ask your dealer

B-P **BARD-PARKER COMPANY, INC.**
DANBURY, CONNECTICUT
A DIVISION OF BECTON DICKINSON AND COMPANY

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THIS SEAL MEANS THREE THINGS

1 *Consistent Quality*

Day in and day out, Ilford Red Seal X-ray film consistently offers these qualities: *To the technician:* Extremely high speed to minimize exposure, prolong tube life and offset involuntary movement of the patient. *To the radiologist:* Superior definition and contrast in bone and tissue detail to aid in difficult diagnoses.

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Since Red Seal is used in hospitals and clinics throughout the free world, its packaging is specially designed to withstand extreme ranges in temperature and humidity. Each 75-sheet box contains three 25-sheet packets, separately wrapped in heavy foil as added protection against moisture and accidental fogging.

3 *Dependable Supply*

Ilford Red Seal is promptly available in the standard 5" x 7", 6½" x 8½", 7" x 17", 8" x 10", 10" x 12", 11" x 14" and 14" x 17" sizes from General Electric, Keleket, Picker, Westinghouse and their authorized dealers.

If your hospital has not yet tested this superior X-ray film and would like to do so, please contact any of the above-named suppliers for a no-cost demonstration.

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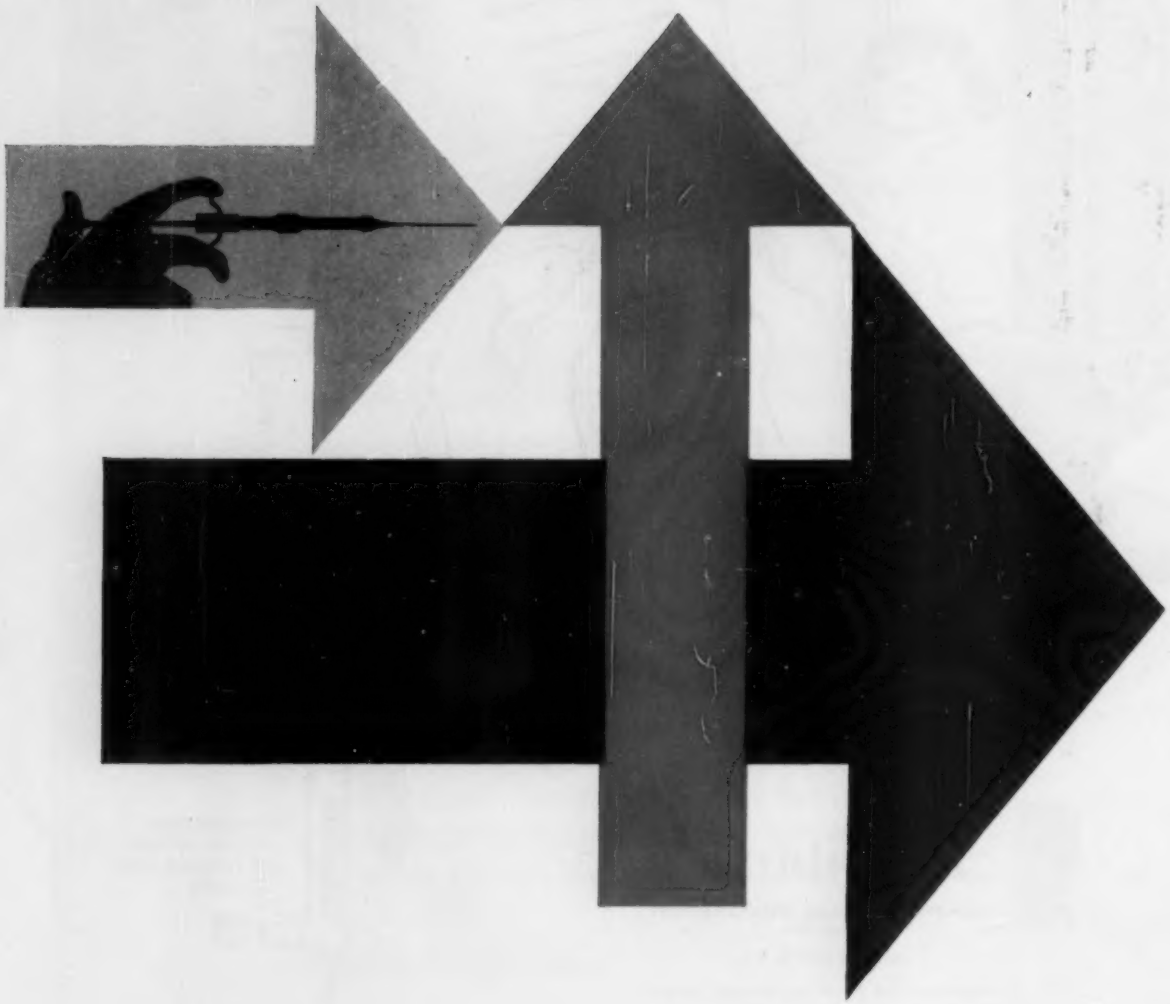

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LENTOPEN® (Procaine Penicillin G in Oil [with Aluminum Monostearate], Wyeth)—300,000 units per 1 cc.

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DIHYDROSTREPTOMYCIN Sulfate—0.5 Gm. per 1 cc., 1.0 Gm. per 2 cc.

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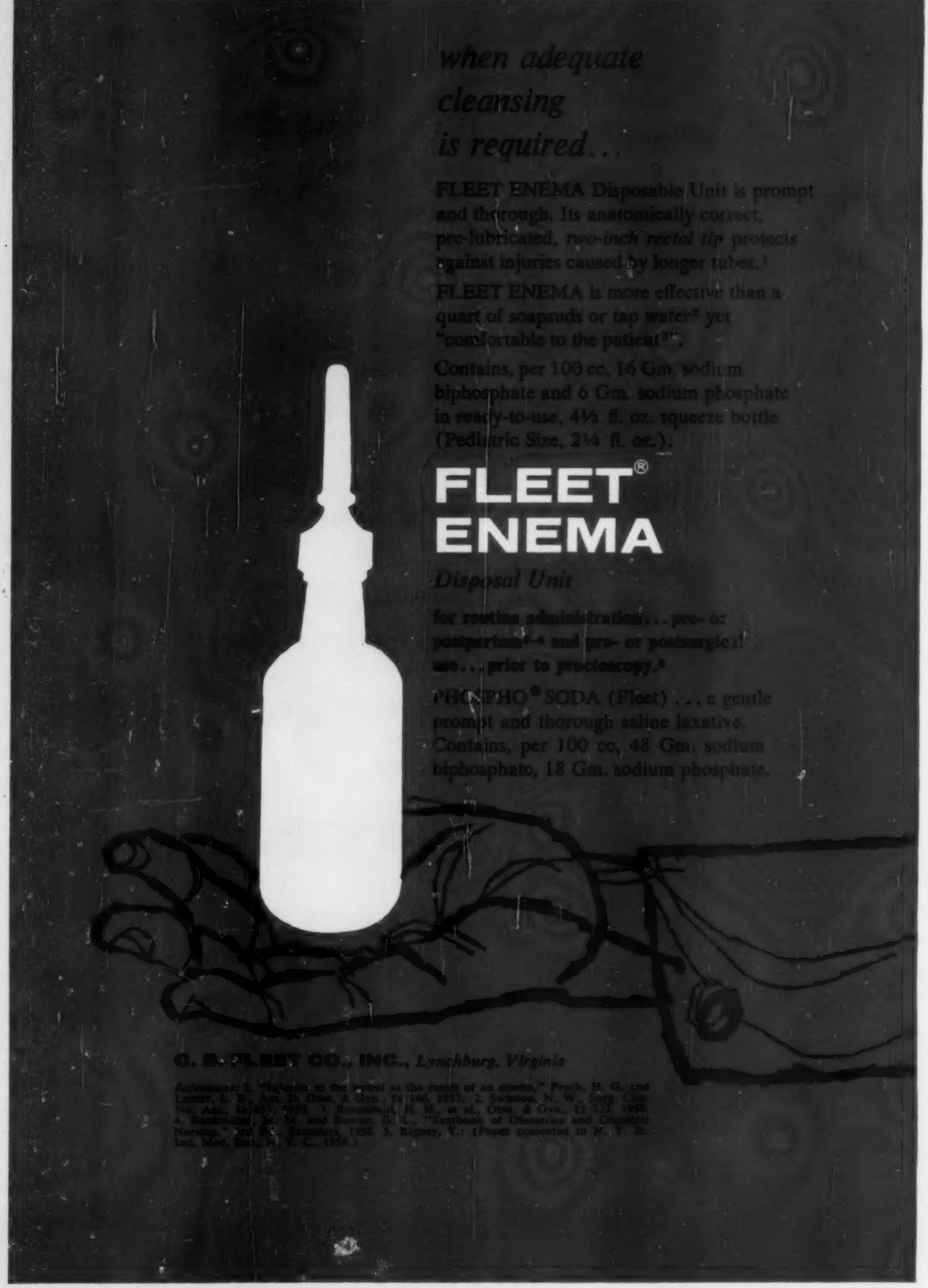
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FLEET ENEMA Disposable Unit is prompt and thorough. Its anatomically correct, pre-lubricated, two-inch rectal tip protects against injuries caused by longer tubes.[1]
FLEET ENEMA is more effective than a quart of soapsuds or tap water[2] yet "comfortable to the patient[3]".
Contains, per 100 cc. 16 Gm. sodium biphosphate and 6 Gm. sodium phosphate in ready-to-use, 4½ fl. oz. squeeze bottle (Pediatric Size, 2¼ fl. oz.).
FLEET® ENEMA
Disposal Unit
for routine administration... pre- or postpartum[3-4] and pre- or postsurgical use... prior to proctoscopy.[5]
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C. B. FLEET CO., INC., Lynchburg, Virginia
References: 1. "Injuries to the bowel as the result of an enema," Prech, H. G. and Lanter, L. R., Am. Jl. Obst. & Gyn., 74:146, 1957. 2. Swinton, N. W., Surg. Clin. No. Am., 35:833, 1955. 3. Rosenfield, H. H., et al., Obst. & Gyn., 11:222, 1958. 4. Bookmiller, M. M. and Bowen, G. L., "Textbook of Obstetrics and Obstetric Nursing," 3rd Ed., Saunders, 1958. 5. Rigney, T.: (Paper presented to N. Y. St. Ind. Med. Soc., N. Y. C., 1958.)

How To Teach "Prep"

Question: In our hospital the patient is prepared by the floor staff for surgery; that is, they shave and clean the skin for the operation. In the operating room we always wash the area with germicidal agent prior to the prep, which is put on by the surgical team. We have difficulty in getting the floor nurses to shave a sufficient area for the operation. Do you know anything that would be of help to us in this problem? Are posters available showing the area to be prepared for different operations and where may we procure them? – M.O.D. – Canada

ANSWER: This query was referred to our operating room consultant, who replied as follows:

"The problem of adequacy of the preoperative shave is not unique to your hospital. My experience has shown that despite posters, teaching and so forth, the general nursing staff of the hospital is usually limited in this technic. You might want to develop a plan whereby a team from the operating room staff assumes the responsibility for an effective shave. This system should not preclude the necessity for continuing to scrub the preoperative area immediately before the operation.

"I know of no commercially available posters or charts that show the areas to be prepared for different operations. However, these can be made easily by drawing on stencils multiple outlines of the human body, then inserting shaded areas to indicate those sections to be shaved and scrubbed."

Duties of Assistants

Question: Would you kindly differentiate between the titles "administrative assistant" and "assistant administrator"? What would be the duties of each?–S.M., Kan.

ANSWER: In reviewing applications for admission and advancement, the American College of Hospital Administrators has had occasion to study the differences between the duties of an administrative assistant and those of an assistant administrator. They have found that the most generally accepted difference between these two jobs lies in their relationship to the administrator. The assistant administrator is generally directly responsible to the administrator. In most cases his duties are sufficiently comprehensive to embrace all of the functional departments of the hospital.

On the other hand, the administrative assistant usually has direct responsibility for two or more specific departments of the hospital and often reports to the administrator of the hospital through the assistant administrator.

These distinctions, however, are not always followed, particularly in institutions with assistant administrators who are physicians and in large teaching hospitals where there may be several assistant administrators with varying degrees of authority and several administrative assistants. Some hospitals are also restricted in their job assignments for these two positions by their by-laws, which may define the job duties of the assistant administrator or the administrative assistant in a more precise or different fashion.

Doctors Get Fee First

Question: We have two doctors in general practice who in some situations require that patients pay their fee in advance before they are willing to help them. These are apparently cases that do not qualify under the indigent program. These patients have no insurance, as a rule, and cannot possibly pay both the doctor and hospital bill in full unless the money is borrowed.

The people we have interviewed in this category have been honest people who are doing their best. The point I am making is that after the doctors have exacted their money in advance the patient comes to the hospital without any money or any propects of borrowing any more.

I recently came from a community where the doctors, realizing the financial problems of a local hospital, always suggested that the patient give the hospital first consideration. This did not mean that the doctors were not to be paid. They merely gave the hospital precedence.

I would like to get some comments on this matter. This hospital has only been open a year. There are not enough doctors in the community to keep the hospital self-sustaining. The population is large enough but many patients continue to go to larger centers near by because of previous association with the doctors there. – W.G.N., Fla.

ANSWER: We referred this inquiry to one of our consultants, who has replied as follows:

"While there is no legal reason a physician cannot demand payment in advance for service rendered to patients, and this practice may not be specifically described as unethical in the Principles of Medical Ethics of the American Medical Association, certainly it would appear to violate the spirit, at least, of the first principle, which states that 'The principal objective of the medical profession is to render service to humanity.'

"While there should be no implication, as you suggest, that any patient should be expected to pay his hospital bill *at the expense of* or *instead of* his doctor's bill, certainly doctors should recognize that the hospital may have more difficult problems of meeting payroll and supply expenses, and in most cases doctors have been willing to acknowledge that the hospital bill should be paid first when some question of means delay is involved.

"Whether this need is acknowledged or not, it may be worth while to discuss the practice of collecting fees in advance with doctors on the hospital staff or, if necessary, with the county medical society."

ANY QUESTIONS?

The Modern Hospital will be glad to try to answer them.

If you have a problem or if you're just curious about a procedure or a statistic, please feel free to write this department, care of The Modern Hospital, 919 North Michigan Ave., Chicago 11.

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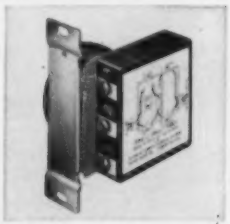
for large number of Flush Valves. Controls urinal Flush Valves for each toilet room in sequence at five minute or one hour intervals according to traffic hours of the building.

DOOR-OPERATED TIMER
employs door switch (not furnished) which starts Timer as user enters toilet room. Flushing occurs within succeeding five minutes while successive door openings have no effect.



SINGLE CIRCUIT TIMER
for flushing one Flush Valve (or two simultaneously).

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for sequential flushing of three Flush Valves. Either one connected to light switch so that flushing occurs only when light is on and toilet room ready for use.

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Pioneered through Sloan research, the system:

- Eliminates the need of user operation
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The Sloan Automatic Flushing System provides accurate electric clock timing; is dependable in operation and trouble-free . . . while saving tremendous quantities of water. The Sloan Urinal Flush Valve is actuated by a Motor Operator (illustrated above); the flushing cycle is controlled by any one of several Timers (explained in captions at left.)

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DRUG INDUSTRY MAKES HEADLINES

Sometime soon the prescription drug industry will be back "on trial" before Sen. Estes Kefauver's antimonopoly subcommittee.

It is a condition the industry had better learn to live with. Senator Kefauver has said he'll hold hearings on and off at least through the spring. They may run on into the summer. Before he is through, Senator Kefauver will have covered at separate sessions every area of the industry where he or his staff thinks prices are too high or there are hints of monopoly—tranquilizers, vitamins, antibiotics and so on.

Only Senator Kefauver, his attorneys, and his economists decide when the investigations will be held, and the subjects to be covered. The companies are told well in advance, and in some detail, the subjects about which they should be prepared to testify. Then they are left to worry just when, or if, they will be called. Each of the 20 companies involved – certain of their records were subpoenaed months ago – must be prepared to send to Washington as a witness an official who can "speak" for the company.

Before the hearings started, Chief Subcommittee Economist John Blair promised the firms would be informed "well in advance . . . at least a month" as to date their witnesses were wanted.

The December hearings are a first-class example of what executives have to worry about when they are in the witness chair.

The sessions extended for six solid days, morning and afternoon, one hearing lasting almost seven hours. Into the record went some illuminating testimony from both sides, but also a mass of junk and endless arguments over what appeared to be minor points.

At the outset of these hearings, Senator Kefauver read a long statement outlining the "charges" that he said the investigation would prove. He won his share of headlines with it.

At the close, he read another statement that in effect said most of the charges had been borne out in testimony. That statement, too, brought headlines.

And in between, the chairman, through his absolute control over timing, was able to make the most of the accusations he, his staff, and subcommittee witnesses produced.

Three witnesses testified for industry, Francis C. Brown for Schering, J. T. Connor for Merck, and Dr. E. Gifford Upjohn for Upjohn Company. Supporting Mr. Connor's testimony were two Nobel prize winners, Drs. Philip S. Hench and Edward C. Kendall. Scattered around them were the subcommittee's or "prosecution" witnesses. These included the head of a small drug manufacturing house, a pharmacology dean who is bitter about "detail men" (who explain new drugs to doctors), the president of a group of retired persons, representatives from the Arthritis and Rheumatism Foundation, and so on.

More damaging to the companies, from a public relations standpoint, were the exhibits prepared by Economist Blair and accusations by him, by Paul R. Dixon, chief counsel of the subcommittee, and Chairman Kefauver.

What did the hearings prove?

Not much that wasn't known before, but they were accompanied by widespread publicity, much of which the industry could not regard as favorable.

But, with one possible technical exception, the hearings did not prove that the industry was engaged in illegal, improper or unethical conduct. Just that the pharmaceutical industry is a high-profit industry, or what the stockbrokers call a "growth industry."

First was the one question that could conceivably find its way to the Justice Department. It was shown that five firms entered into a licensing agreement on two drug products prior to the time a patent was granted on them – in fact, the patent hasn't yet been issued. The firms agreed to pay royalties to Schering – probably on the assumption Schering was the most likely to get the patent – for a period of three years, now expired.

The firms also agreed not to sell in bulk to other companies. This would seem to be the basis for a monopoly charge, coming before issue of the patent. (After issue of the patent, the patent holder is fully protected by law to do almost anything he wants with his patent rights.) However, it was brought out that not only was no effort made to enforce this "no bulk sales" agreement, but that in fact bulk sales of the products were and are common.

However, Chief Counsel Dixon thought enough collusion had been shown to justify this warning: "If there was restraint (against bulk sales), then this was an outright violation." The issue would seem to be whether the agreement per se was in restraint of trade, even if it was not enforced.

Witnesses for two of the other four partners to the agreement said that no enforcement had been attempted, and that the prepatent agreement was only in the nature of an "insurance policy" to guarantee all parties that they could remain in production after the patent was issued, paying royalties to the fortunate company.

Some of the other points raised:

The industry's over-all profits are high. Senator Kefauver said they were the highest of any industry for the last three years. This is not borne out by other information, but there was no denying that the margins ranged from 10 to 16 per cent and in a few rare cases more.

When a company puts a new and valuable drug on the market, it usually makes a fat profit for a few years. Indus-

try explains that often this is necessary merely to recoup heavy expenses incident to research and development of the product. Not satisfied with establishing this fact, which is no secret to anyone, the subcommittee's chief economist, John Blair, tried to build up this issue by means of what became known as a "numbers game." It was operated this way:

Mr. Blair would take first the price at which the company sold the product in bulk. Then from a second company he would get an estimate of what the cost would be to bottle and package the drug for resale to wholesale drug houses or pharmacies. Finally he would contrast this "cost" with what the original company actually did sell its drug for, labeling the difference the company's "mark-up." Thus it was possible to brand the companies with "mark-ups" of from 1000 to 10,000 per cent. Naturally, many headlines were thus created.

Industry's defense was that this bit of arithmetic was a "myth." It didn't take into account the company's major expenses — advertising and promotion (including cost of detail men), administrative expenses, exacting control procedures in processing, taxes and research.

This explanation was supplied by the first witness, Schering's Francis Brown. Yet the subcommittee continued to play its game throughout the week. The final witness, E. Gifford Upjohn of Upjohn Company, went a step farther. He insisted on getting into the record his firm's over-all 13 per cent profit rate, instead of the subcommittee's astronomical figure, then giving in detail the items that make up the 87 per cent of cost.

Two other issues resulted in just about a standoff. The subcommittee pointed out that promotion, advertising and detail men require about a third of every sales dollar. Senator Kefauver charged that this was too high. The industry's representatives said it wasn't.

It was brought out that about 71 per cent of all prescriptions are written in drug trade names, rather than generic terms. Also, that in some cases if the generic names were used there could be a saving to the patient. One subcommittee witness said doctors should be "educated" to use generic names. On this there was no solution in sight as the week ended.

HOSPITALS MAY BE INVOLVED LATER

So far, hospitals have not been directly involved in the hearings, but don't be surprised if they are later.

Several subcommittee witnesses discussed hospital formularies as an example of how drug prices can be reduced by use of generic names, or substitutions approved in advance and in writing by the doctors.

It will be no particular surprise if a few hospital administrators are called up to describe more fully the economy value of formularies. Then would come the question: Is the saving always passed on to the patient, or does the patient pay as much for a generic name drug as for the well known trade name drug his doctor might have prescribed?

FEDERAL INSURANCE CARRIER NAMED

The Civil Service Commission has drawn up its timetable for the federal employe health insurance program, scheduled to start July 1. Under the plan, contract negotiations **are to be completed by March 1. A major decision was the selection of the Aetna Life Insurance Co. of Hartford,** Conn., as the carrier for the nationwide indemnity phase of the program. Negotiations still are going on with Blue Cross-Blue Shield, the comprehensive plans, and the many federal employe union and association plans.

Under the law, Aetna is required to parcel out to other qualified companies part of the business, the exact amount to be determined by a formula based on the health insurance each is carrying.

Each year employes who do not enroll originally will be given a period in which they can join, regardless of age or medical condition. Also, during this period enrolled employes may shift freely from one plan to another. This open period will be from October 15 to 31, except for next year when there will be no open period.

One stipulation is that employes dropped from government will have the right to carry on individually, regardless of age or medical condition. In this case, of course, the government contribution will cease. Those quitting their jobs do not have this right, but those who retire do have it.

Even if employes do not want to participate, they will be required to fill out a form so stating in writing. No plan will be allowed more than four rates, two for the standard program and two for any more extensive coverage that is offered.

The U.S. is offering to pay $6.75 per month toward family coverage, if the policy's total cost is at least double this amount. If the total cost exceeds $13.50, the extra amount must be paid by the employe. Because no companies are planning to issue policies at a total cost of less than $6.75 per month, some of the lower paid employes, who feel they can afford only a few dollars a month, will continue to go unprotected.

A.C.S. Names Dr. North Director; Appointment Takes Effect in 1961

Paul R. Hawley, M.D.

John Paul North, M.D.

Dr. John Paul North has been named director of the American College of Surgeons. His appointment becomes effective Jan. 31, 1961.

Dr. North, a surgeon and educator from Dallas, will succeed **Dr. Paul R. Hawley,** who has served as director of the college since March 1950.

A graduate of the University of Pennsylvania medical school, Dr. North has served as chief of surgical service at the Veterans Hospital, Dallas, since 1955, and as professor of clinical surgery at Southwestern Medical School of the University of Texas since 1946.

The Modern Hospital
JANUARY 1960

LOOKING AROUND

Forecast

WITH all the hand-wringing and doom-crying that is going on about Blue Cross these days, we like to think back to a conversation with a friend of ours who was one of the early leaders of the hospital service plan movement, which was regarded at the outset by businessmen as a little fuzzy and by physicians as downright radical.

"How many people do you think might be enrolled, ultimately, in these hospitalization plans?" we asked our friend as we came out of a meeting one evening.

"Shouldn't be surprised some day to see a half million people enrolled — nationally, of course," our friend said.

We thought he was smoking opium.

Semi-Science

IN BUSINESS and in the army, the putative distinction between line and staff is plainly understood on all sides: Line authority moves downward from the top in dog-beat-dog layers and is responsible for carrying out the purposes of the enterprise. Staff positions are generally without authority and are concerned with means rather than ends. In many organizations, however, the distinction is not as clear in practice as it is in theory. Sometimes the allocation of authority is fuzzy to begin with, and sometimes staff officers tend to take on line authority, with or without management's consent. "Give an assistant a staff assignment and — especially if he's a good man — the first time you turn your back he's giving orders all over the place," said one experienced executive who takes a dim view of administration by text instead of by task.

In the hospital, line and staff relationships are upside down anyway, because the purposes of the enterprise are carried out by professional staff members having no line authority as such, and line management is largely concerned with ordering the means for achieving professional ends. This reversal of scholarly text is the subject of a scholarly text by a sociologist who tested the accepted theory and concluded that it wouldn't stand up in a hospital corridor.* "In professional organizations the generalizations do not apply and therefore can no longer be seen as valid generalizations of organizational theory," the author said, exercising the sociologist's predilection for stating a simple proposition in complex terms.

Explaining how it happens that line and staff roles are reversed in professional organizations, the social scientist describes many differences between the administrator and the expert or professional man as personalities. "The expert typically deals with symbols and materials," it is explained. "The manager deals with people. The two role types require different personality types. The expert who has intensive knowledge in a limited area tends to have a restricted perspective. The manager has extensive, though limited, knowledge of many areas, and the resulting broad perspective is essential for his role. Managers are skilled in human relations; experts are temperamental. Managers are more committed or loyal to their specific organization than are experts. Experts are often primarily oriented toward their professional and membership groups. While managers are often committed to the organization's particular goals, experts are committed to the scientific and professional ethos regardless of the particular needs and goals of their institution."

No strain so far. The trouble is that managers with no training or orientation in the "goal activities" of the organization may confuse means with ends or "reverse the hierarchy of values." The resulting ritualization of means may undermine the goals for which the organization has been established, it is pointed out.

This disaster can be avoided by putting an expert or professional man at the head of the organization, but, it turns out, this may create as many problems as it solves, because "organizations have functional requisites that are unrelated to their specific goal activity . . . an expert may endanger the integration of the professional organization by overemphasizing the major goal activity, neglecting secondary functions, and lacking skill in human relations." The role of leader of a professional organization, unhappily, "requires two incompatible sets of orientations, personal characteristics, and aptitudes. If the role is performed by either a lay administrator or a typical expert, considerable organizational strain can be expected."

Fortunately, sociology has found a way out — rule by the semi-expert, or specially trained administrator. "The advantages of specialized administrators over lay administrators [defined as those who have no training at all in the goal activties of the organization] are obvious," the author concludes. "They are trained for their peculiar role and have considerable understanding of the organization in which they are about to function before they enter it. They are sensitized to the spe-

*Etzioni, Amitai: Authority Structure and Organizational Effectiveness. Administrative Science Quarterly, 4:43 (June) 1959.

cial tension of working with professionals, and they share some of the professional values."

The semi-expert qualifies for his assignment by combining an expert background with a managerial personality, it is explained. "Goal as well as means activities seem to be handled best when such a person is the institutional head."

Plainly, hospital administrators must be considered semi-experts. "In recent years there has been a movement toward developing more and more specialized administrators, such as hospital administrators and educational administrators," it is reported.

Closing its case with a final warning, social science points out that "it is important to distinguish between an institutional head and an institutional figurehead. Since the institution needs legitimation in the eyes of the personnel, clients, and community, and this legitimation has to be of a professional type, there is a tendency to nominate as institutional head a well known expert. Although this means in some cases that an expert takes over control of the organization, much more frequently it means that an expert is lost and becomes a semi-expert, or that the expert is the figurehead and some other person actually has primary authority."

Turning the Screw

OBSERVERS who attended the American Medical Association's House of Delegates meetings in Dallas last month may have witnessed an extraordinary instance of iatrarchical suicide: Seeking to safeguard a fraction of their freedom, the delegates touched off a chain of events that might, eventually, destroy the whole of it. That some, at least, of those who took part may have sensed what could happen as a result of their actions seemed apparent from a notable lack of enthusiasm for the proceedings on the part of many who are customarily in the front ranks when medicine's independence is in question. Even the hallelujah shouters from Mississippi and Louisiana were somehow subdued; the old phrases about Private Practice and Free Enterprise and the American Way of Life were there, but the old fire was not.

What was under discussion was commonplace enough – the "corporate practice of medicine" by hospitals employing pathologists and radiologists and billing patients for their services; and what was done seemed harmless enough – simple reaffirmation of a 1951 statement of principles asserting that such practice is contrary to the policy of the American Medical Association. What was different was that the pathologists and radiologists who initiated the action this time were obviously prepared to use it to the hilt against the members of their groups who refused to get in line; and what was ominous was that such use might be construed as restraint of trade by a government department which 20 years ago defined the practice of medicine as a trade within the meaning of the law.

Armed with resolutions from a dozen state medical societies, the pathologists and radiologists who wanted the 1951 principles reaffirmed for their own purposes had the drop on any physician who may have had misgivings about their intentions; the proposition was presented in such a way that a vote, or even a voice, against it was a vote or voice in favor of "lay control" or medical enslavement. "There isn't a thing we can do about it," an A.M.A. official told an onlooker, risking censure by implying some doubt about the wisdom of the impending maneuver. Asked what the resolutions were all about, a surgeon said sadly, "We're still trying to make doctors out of pathologists – and it's uphill work."

Pathologists and radiologists themselves were by no means unanimously happy about the triumph of their strategists. "I'm perfectly satisfied with my arrangement," a salaried pathologist told a friend, "but I have to go along." Another pathologist, who led the move to get the resolution passed in his state, told a medical plan administrator: "Don't be misled by what I *say* in these meetings. Just leave things the way they are – as long as you can." When a delegate speaking for the resolutions at the A.M.A. reference committee hearing declared that "the radiologists in my state are men of good will," an associate in the back of the room added, *sotto voce*, "– and rich!"

Unquestionably, the radiology and pathology organizations will now start tightening the screws on members who let hospitals bill patients for their services. Sooner or later, some physician who loves his freedom enough to resent encroachment by medical organizations as much as the organizations resent encroachment by hospitals will fight back when the screws start to turn. Eventually, then, the issue will be resolved by a court which must decide how far an organization can go in preventing one of its members from purveying his services to the public by a method of his own, and the public's, choosing. That could be a bad day for physicians, if not for freedom.

Quack

THE New York State Medical Society has passed a resolution deploring use of the designation "Dr." indiscriminately to embrace doctors of chemistry, law, divinity and quackery, as well as medicine. To protect uninformed and misguided people from accepting treatment offered by any joker who calls himself "Doctor," the society has initiated a campaign urging physicians to use "M.D." instead of "Dr." The society now wants the American Medical Association to "organize and implement a national campaign to encourage physicians to use 'M.D.' after their names instead of 'Dr.' before and to inform the public of the meaning of 'doctor of medicine' as contrasted with other 'doctor' designations."

Well, most physicians already use "M.D." after their names in writing and "Dr." before in conversation, and we can't see how a national campaign, or any other method, is going to get people to say "Jones, M.D." instead of "Dr. Jones." Certainly it would be neater, and safer, if the means were at hand for instant recognition of the physician as opposed to the quack, but we can't believe that anybody is harmed by the practice of referring to chemists and philosophers as "Doctor" if they have earned the title, as many did centuries before the term was used for physicians. British surgeons get along nicely with the designation "Mr." – possibly understanding, as Socrates did, that virtue is more to be admired than the appearance of virtue.

Besides, nobody can organize and implement a national campaign, whatever that comprehends, that will prevent quacks from referring to themselves as "Doctor" – for reasons that became clear to us some years ago when we were attending a medical convention and came back late one night to our room at the headquarters hotel.

"What do you do for a bad case of sunburn, Doctor?" the elevator operator asked us as we went up together.

We told him.

What Hospitals Should Know About Fund Drives

The capital needs of American hospitals are estimated to reach a high of $10.02 billion in the next 20 years.

Competent authorities expect some $5.5 billion to come from private sources; to meet this figure, $275 million must be raised annually. In 1958, voluntary contributions to hospitals for capital purposes fell short of this by nearly $35 million.

Clearly, fund raising will play, must play, an ever increasing role in hospital financing if this challenge is to be met. Trustees and administrative staffs, too, must become increasingly familiar with professional fund raising principles and technics, which are examined in detail in the articles presented in the succeeding 13 pages.

Who Gives How Much To Campaigns

Study of 40 fund campaigns tells who gives, how much is given, and what it costs to carry on a campaign

CAMPAIGN costs are declining while campaign income is rising, according to a survey of 40 hospital fund raising drives conducted in 1958. A statistical summary of these campaigns sheds much light on who gives, how much is given, and what the costs of a fund campaign are. The information was obtained from the 28 member firms of the American Association of Fund-Raising Counsel, Inc., whose membership covers the United States and Canada.

In the 40 campaigns studied, more than $65.5 million was raised. Of these 40 campaigns, 33 exceeded their goals by amounts ranging from 0.1 per cent up to 44 per cent. More than 5800 gifts of more than $1000 were contributed.

The summary covers a geographical cross section of American hospitals and examines individual campaigns with goals ranging from a low of $200,000 to a high of $5.7 million.

The information established indications of trends of giving from five contributing sources: corporations, employe groups, individuals or community, trustees, and medical staffs.

Corporations. In 30 campaigns, corporations contributed a median of 33.5 per cent of the goal. The highest contribution rate was 71.5 per cent, with wide variance in rate from campaign to campaign. The heaviest concentration of corporate giving occurred in the five largest campaigns, each of which sought more than $3 million. But even in campaigns with limited goals, corporations contributed from 12 to 44 per cent of the total.

Corporate giving has doubled in the last decade, offsetting declines in other patterns of giving. Experienced professional fund raisers find corporate philanthropy strongest in urban areas of middle size which contain a high proportion of industry, such as Syracuse, N. Y. These attributes of size and population density lead to a close affiliation between the individual and hospital.

Small urban corporations are inclined to participate actively in fund drives, and generally allow exceptions to the once-a-year rule on employe group solicitations for capital drives.

Another area of present-day corporate expansion in American philanthropy is the increased matching of funds donated by individual employes and employe groups. This is related to new personnel and public relations practices of the last 20 years.

Employe Groups. Collective contributions raised through solicitation of employe groups varied widely, reaching a high of 29 per cent in the largest campaigns. Professional fund raisers look to employe groups as a vital source of funds in the future. The relatively easy access to these large numbers of potential contributors is a factor in cost analysis that is further bolstered by the high rate of contributions as a result of favorable group attitude. Employe contributions were not reported in the smaller campaigns with goals reaching up to $385,000. However, it can be stated that in the campaigns of from $737,000 through $1,000,048, employe groups bore a fifth part of the campaign goals and in the top five campaigns as high as one-third.

Community. The size of the community has an important bearing on the enthusiasm with which it supports local fund drives. Community giving reported in the survey ranged from a low of 1 per cent to a not infrequent high of 88 per cent. In these same campaigns corporate giving ranged between 9 and 44 per cent. The report

Businesslike management methods and professional help are combining to reduce fund campaign costs and raise income, this report shows

revealed that community giving was an increasingly important source of funds in the smaller campaigns. This may be understood in terms of the close affiliation between the smaller community and its local hospital as contrasted with large urban areas.

There are many factors to be taken into consideration in soliciting the general public. A.A.F.R.C. experience indicates greater success with community drives when an appreciable part of the campaign goal is already assured by precampaign gifts. Says one fund raising counsel: "The community responds with a sense of achievement and finds satisfaction in being able to meet – and exceed – the campaign goal."

These figures and reports by fund raising experts encouragingly point to a growth of community giving in hospital philanthropy.

Trustee and Medical Staff. A median of 5.4 per cent of campaign goals was contributed by trustees. The highest per cent of trustee giving reported was 16.8. It reached a low of 1.1 per cent in the biggest campaign.

In the intrahospital group, medical staffs contributed a median of 11.2 per cent. Contributions ranged from a high of 37.5 per cent to a low of 0.09 per cent.

Trustee and medical staff giving varied widely from campaign to campaign. Peak participation was achieved in the campaigns with goals of $755,000 to $1.8 million. Again, this may be attributed to the close affiliation between staff and hospital in the small and middle-sized communities, according to competent fund raising authority.

Definitely on the increase, the figures reveal, are gifts of more than $1000. These provided a median of 70 per cent of the total raised in 28 campaigns. The lowest per cent was 32.5.

In the biggest campaign, 456 large gifts accounted for 62.4 per cent of the total raised. Some 604 gifts accounted for 83.6 per cent of another of the top five campaign goals.

Large donations increased with the scope of the campaigns and can be considered a strong trend in patterns of giving, as revealed in the report.

In campaigns which exceeded their goals but still reported total contributions of less than $300,000, big giving accounted for an average of 51 per cent of goals.

Costs

The fact that 33 of 40 hospitals surveyed exceeded their goals is evidence of a high degree of cooperation and participation between outside counsel and hospital management.

But what of the costs of using outside counsel – success at what price?

The highest cost of any campaign reported was 9 per cent of the total raised; the lowest, 4.3 per cent. It should be borne in mind these are total costs – printed material, clerical help, rent, feature events, and professional fees.

What factors determine costs? As might be expected, costs were proportionally lower in the larger campaigns. But, chief yardstick in determining costs is the duration of campaigns.

Costs ranged from 3 to 6.8 per cent of the goal in the smallest campaigns, while they dropped to 2.5 per cent in the five largest drives.

Note that these figures are reported in terms of percentages only to establish a clearer relationship between costs and contributions. Member firms do business only on the basis of a fixed fee. They will not serve clients on the basis of a percentage or commission on sums raised.

Of those reporting the duration of their campaigns, 22 spent an average of 11 weeks in preliminaries and 35 reported an active period of 15 weeks. The smallest campaign in the survey reported a preliminary period of from two to four weeks and an active period of 12 weeks; another exceeded its goal in four weeks total. Active solicitation in the five largest campaigns varied between six and 26 weeks.

Generally, fund raisers who have spent considerable time working with hospitals feel that costs are directly related to: (1) the speed with which competent counsel is reached; (2) the efficient cooperation of hospital administrators and trustees; (3) determination of realistic goals, and (4) agreement on a set fee.

Workers

The number of professional staff members assigned to the reported campaigns never exceeded six. The number of staff was proportionate to the size of the campaign and to the listed volunteer workers participating. In the median campaigns two professional workers served as aides, and in the five largest – three, four, five and six, respectively, were assigned.

The five largest campaigns averaged 2329 volunteers, with a low of 60 to 375 volunteers reported in the five smallest campaigns.

This is particularly noteworthy in view of the reported shortage of volunteer workers in American philanthropic causes. Professional fund raisers feel that hospital campaigns generally draw a greater proportion of volunteers than do most other philanthropic campaigns. ■

How To Conduct Campaigns:

Hugh N. Brown

This is how the fund raisers work, what they do, and why they do it

MANY hospital people have had a close brush with fund raising. Their views are shaped by these experiences — sometimes erroneously. If money raising were a science and the campaigns conformed to scientific postulates the matter would be simpler. However, it is not a science, it is an art. What has happened in other campaigns serves only to establish "patterns and principles"; it does not necessarily have practical value in designing and carrying out a new campaign.

Therein lies the justification for use of professional fund counseling firms and free-lancers. Unique skills of career campaigners and their "how-to-do-it" experience can, and usually should, be coupled with local knowledge.

An expansion or hospital restoration program breaks down into phases: the pre-preliminaries, the preliminaries, the campaign itself, and the post-campaign period.

Test questions for use during the pre-preliminary stage are boxed on page 62.

Once it is determined that a campaign will be undertaken, the problem of campaign direction must be faced. If the decision is to import professional counsel, where do you look, what will it cost, what can they bring to the job?

Taking these questions one at a time, we "look" to the 40 or 50 firms or any one (or combination) of the 25,000 free-lance campaigners. The American Association of Fund-Raising Counsel[1] would say "look" to its 28 member firms. Companies not in the association would point to their fine production record and suggest that one could do no better than hire one of them. The free-lancer would rationalize his appeal by casually mentioning that he had worked years with the top firms, and furthermore, he would direct the campaign.

Established firms do not guarantee the amount of money they will raise. They do pledge a professionally directed service. Professionals seldom get an easy campaign; often they are called in after one or two abortive local starts have compounded the problem.

There is a relationship between initial community money raising surveys and the placing of fund counsel under contract. These surveys involve professional companies during the period of sale of the campaign.

Check Success Potential

After the word is out that the hospital is anticipating a campaign, officers of the fund firms, or experienced directors currently assigned to campaigns in the immediate area, come to the community (on invitation), talk with key citizens, check out economic and other factors peculiar to the city and environs. They reach rather rapid conclusions about the success potential of a campaign and the time anticipated to achieve the dollar objective. The experienced sales person can assess quite well the community's ability and willingness to give the initially established target amount.

Some companies make extended studies which may have more sales pitch value than merit. A few firms put great emphasis on this initial survey — they charge more than $2000; use a pseudo-scientific approach, and accept only those programs which reflect positively.

Determination of an attainable goal, sufficiently large to cover construction and related costs, hides a "sleeper." The hidden significance is that *the cost of the delivery is based indirectly*

[1]Loose affiliation of the top companies — offices in New York City.

From Selecting Counsel to Collecting Pledges

on the amount to be raised: The more money, the longer the service.

If a hospital development corporation has been formed to carry forward the community-wide hospital expansion, hiring of fund raisers will rest with that body. If not, the hospital board will usually conduct the interviews, after initial screening by the administrator. Competitive sales technic spices the conferences.

Most firms estimate costs of the campaign delivery on a man-week basis. The number of professional campaigners assigned will vary depending upon the sales person's appraisal of the job. Costs level out to $100 or $125 per day per man. Usually, an extra $100 per week is charged for the chief counsel, as the director is known. Obviously some "give and go" in negotiation takes place.

Here, from an actual contract, are expenditures reflecting time-fee-manpower relationships:

Five Men – total 88 man-weeks to be delivered over a period of 21 weeks, October 13 through February 28 (Christmas Week out).

Chief Counsel – 20 weeks, October 13 through February 28.

Two Associates – same period as chief counsel.

One Associate – 20 weeks, October 20 through March 7.

Publicity Specialist – 8 weeks, subject to broken service to coincide with requirements of the campaign.

Fee – $43,900 to be paid as follows: $5000 at time of signing of contract. Balance to be paid in four installments of $9725 each on November 29, December 20, January 24, and February 28.

Local Expense (estimate) – $28,000.

The contract stipulated that the goal should not exceed $1.5 million and was expected to shuffle down to something between $1.25 million and $1.4 million (eventually set at $1.3 million).

As it worked out, total cost was $72,441. The fee remained as projected and local expense exceeded the $28,000 estimate by only $541. There was one catch – *this campaign did NOT achieve its goal!* It was a brain-kit[2] or stereotyped, uninspired delivery. One tip-off is that expenditures came out so close to projection. Top campaign directors often shock the client with their opening remark: "I'm on the scene now – here is a revised estimate of local expenses." His educated projection will be closer than that provided by the sales person – he *knows* how *he* spends.

By contrast, another delivery handled by the same firm (different director) told a positive, dollar-production story. On approximately the same size goal, the campaign cost $83,387 – but, the money was obtained! Expenses were higher because of a long period of public relations service by the chief counsel. Superb strategy and human relations manipulation made a difficult campaign possible.

In both of these cited campaigns the client cooperated well.

[2]Brain-kit means footlockers or portable reference files carried by campaigners.

Cost of 3 or 4 cents on the dollar raised is acceptable in hospital intensive campaigns. Long-range development programs for hospitals parallel somewhat college programs – costs run from 15 to 25 cents on the dollar.

Informing clients of expense prior to a campaign has stabilized the profession (better firms have always charged a set fee). Fly-by-night operators who take excessive percentages of the goal are now a rarity.

When the fund raising team arrives, its first tasks are to establish headquarters, build and refine prospect card files and related mechanical operations, draft the plan of campaign, prepare the case for giving, establish "memorials," produce conditioning-training literature, and carry out other public relations activities.

With these preliminaries out of the way, efforts are directed toward relating construction plans to the proposed money goal. These include:

Devising of localized formulas for corporate and individual giving and preparation of specialized presentations for approach to significant prospects.

Education and instruction of previously enlisted volunteer solicitors.

Matching of prospects to solicitors and projection of the campaign

Hugh N. Brown is a free-lance fund counsel and public relations consultant. In his 18 years' experience as public relations practitioner, fund raiser, association executive, administrator and organizer for hospitals and higher education he has studied fund raising from the point of view of the client as well as the career campaigner. He has been associated with eight hospitals in six states and with eight colleges and universities in five states.

Campaign director piles work on volunteers – from the chairman right on down the line

through soliciting divisions and control of those units.

Final surge toward the Victory Dinner (periodic report luncheons and meetings will have been held after the individual divisions were kicked-off) including eleventh-hour adjustment and use of held back strategy.

Full collection of the subscribed funds over the spanned pledge period.

Listing events and the sequence in which they may occur implies that there is a set way. Actually, determination of the steps with implementation and modification is a prerogative of the director, who determines the timing in the manner he thinks most beneficial to the campaign. Without question, the hallmark of a truly professional campaign is able direction.

The use of fund raising counsel increases the client's work. The director is a specialist who drafts the blueprint, revamps it as necessary, and uses finesse and community pressures to accomplish hundreds of small objectives leading to oversubscription. He piles work on volunteers, from the general chairman down. Soon he may be considered a ruthless driver, although generally he will be respected for his organizational touch and campaigning sixth sense.

The Director Runs the Show

All the resources and accrued knowledge of the firm and its officers are at the disposal of the director (and the client), but the director runs the show. The fluid nature of a campaign demands that the one on the scene be in the driver's seat. Chief counsel does represent the company. Many directors serve on their firm's board, although they can be reassigned should the client have valid reason. It behooves the firm to send in the best director possible and it tries to get the best talent on the most demanding campaigns.

Scheduling of staff men may conflict, thus prompting a wait for a preferred director. This can prove to be a very intelligent decision on the part of the client.

Directors take pride in "seeing" the money in a community. They have pet theories revolving around timing, giving formulas, and other technics of getting the dollars pledged. Better producers favor a long period of preparation with only a short time for solicitation. This makes the program appear lethargic at the outset and leadership sometimes becomes alarmed, but when the money does start to flow – it floods!

Report Gives the Facts

Two reports are of genuine importance. One, the sales report, the client never sees. It gives terms of the contract, economic and service facts, and impressions about the hospital, the community and its leadership. This briefing from the company sales person is put in chief counsel's hands prior to arrival on the local scene.

The other, the final service report, is a summary of what happened during the campaign. It reflects dollar production by divisions, memos, correspondence and all documentation of the campaign. A copy of the report is sent to the home office with the original given to the client. Often, directors will make a third carbon for their own files. The report then supplements the thick ring books used to control the divergent action of money raising.

To illustrate the danger of oversimplification, consider that the plan of campaign was listed earlier as only one of the preliminaries. The plan differs in every instance. It is the scheme of organization accompanied by an intricate, interlocked time schedule upon which the campaign is paced. In content it spells out the philosophy, defines the objectives, states and elaborates upon the phases, outlines leadership requirements, establishes a job analysis for the top chairmen, advocates formation of special boards and groups (to broaden appeal base), touches upon special dinners (to build up emotional enthusiasm), lists the divisions of volunteers and how they will carry responsibility, clarifies work of committees (public relations, audit), recommends the best pledge structure, and holds the master timetable.

Obviously, this basic document must be the brain child of a craftsman. It requires not only experience, but intuitiveness reflected in a blueprint which will work and still be acceptable to the client.

Each division in a campaign should have its own plan (later developed segment of the master plan) with emphasis on educational training. When a multiple staff of trained fund raisers is on hand the job is easier. Without exception the director will handle the heaviest producing divisions (usually three or four) as indicated by the donor evaluation sessions. These divisions produce the nucleus money (70 to 85 per cent) while the smaller gift divisions produce the oversubscription. The number of these divisions will vary from six to 18 depending upon the director's study of where the money is and how to extract it.

Staff Gifts Set Pace

Carded prospects on a multimillion dollar hospital campaign can run to more than 100,000 (usually from 5000 to 20,000) of which one-fourth will give. Hospital personnel and the medical staff are asked to give as pace setters. Advanced gifts are in the picture for the same reason, plus providing a big money "running start."

Medical giving normally is set on a ratio of the goal and ranges from 20 to 35 per cent of the dollar objective. A committee of key doctors to negotiate on the collective and individual target gift (by type of hospital affiliation) is the standard procedure. Often this original committee conducts the medical solicitation. In the last 10 years physicians have given more than $500 million to hospital campaigns, according to the American Association of Fund-Raising Counsel.

The client should not be overly impressed by publicity and promotion. Its impact is in the area of general conditioning and a nice scrapbook, not in dollars.

Formation of a volunteer auxiliary can change the giving climate positively and should be considered if such a group is not in existence.

As a sidelight, motivation to give stems from the human spirit, the established pattern, and finally, self-interest.

(*Continued on Page* 62)

Why This Project Never Made the 'Parade'

Nancy Lane

SOME hospital fund raising efforts pay off handsomely and get themselves on the project parade at national conventions. Who's to tell the tale of the duds, the busts, the flopperoos? Perhaps that's my mission, for I have survived several.

At every week-end or week-night gathering in our chain of suburbs, the backyard barbecue is exclusively hot dogs. This has gone on for six determined months. It isn't that we have given so much money to the hospital campaign that we can't afford an occasional steak; it is just that we girls have given so much of ourselves. And thereby we have accumulated a hot dog surplus that would astound the Secretary of Agriculture, a hard man to astound, surplus-wise.

Last spring Jeanne Meadows brought word to the hospital guild in our subdivision that some non-hospital group had made $500 in one day by selling hot dogs and doughnuts at our sharp new scalloped-roof shopping center. If those people could do it, why couldn't we with our fine humanitarian purpose?

Jeanne and I were named co-chairmen. With confidence and efficiency we ordered 1000 wieners and rolls, 100 dozen doughnuts, and pop by the case. On the designated Saturday we took our places on the plaza, half a dozen women for each three-hour shift. Our reluctant husbands had set up the stands the night before at two strategic sites on the shopping center grounds.

Saturday dawned too early but not bright. We volunteers unloaded our cargo, put up our hospital campaign posters, and assumed gracious smiles for the first cash customer. All week the skies and water had been bright blue. This morning a gray gauze curtain of mist was settling over the plaza, the valley, and the hills. A damp chill stole through our vari-colored sweaters and crept down and up our budget-floor frocks.

Diane Davies, one of our co-workers, arrived characteristically late and breathless. This time she was gasping validly: "Did you see the big signs at the supermarket? They're giving away a cup of hot coffee and a new brand of cookies to every customer — and lollipops to the children. Today, of all days!"

At this all of us turned a little colder. We straightway started some animated chatter, but it was difficult.

Some close friends came up to our stand to say "Hi" before going to the market for the week-end's grocery shopping. Unenthusiastically they bought a wiener and bun from our eager hands.

The day didn't improve. Nor did business. Our husbands came, shopped through the grocery lists we had left for them on the kitchen counter, had a cup of hot coffee in the supermarket, and came dutifully over to buy a doughnut or hot dog. Our children, whom the dads of necessity had brought along, stuffed a hot dog and roll into their mouths, still sticky from a gorge of free lollipops.

The hours stretched. We early birds hung around to cheer up the second and third shifts, our presence lending the stands some semblance of popularity. Around 5 p.m. we totted up the day's take. We had sold precisely 80 hot dogs, 73 doughnuts, and 10 bottles of pop.

Let us render thanks to the creator of installment buying — and to its food freezer category. Down into two dozen home freezers went the 920 hot dogs and buns; down into the same or next-door freezers went the 1127 doughnuts. The cases of pop were carted back for credit.

Then began the Big Wiener Push of 1959. No assemblage of four or more for social, civic, cultural or moral reasons but must pay for, thaw and consume a generous quota of buns, wieners and doughnuts. When the weekly community newssheet reached us, we pounced upon it, scanning each item. If any group or family so much as threatened to gather, one of us ran to the telephone insisting that their board be made festive with hot dogs and doughnuts.

At long last September came and school resumed. We maneuvered the P.T.A. into a position where the birthday of every first or second grade child was celebrated by a wiener and doughnut feast for the entire room, Mom (or secretly the P.T.A.) footing the bill. The kids constituted the only segment of the population not surfeited with hot dogs.

Now, thankfully, it's over.

Come the last Friday of the month, Dr. Amos Andrews, a retired physician and chairman of the board of our new hospital project, will stand in the drizzle — it will most surely drizzle — and make a quick incision into the brown belly of a hilltop with a silver-like spade. As he turns the first ground for Memorial Hospital, the rest of the board and all the guild chairmen will solemnly watch.

Close by their muddy heels will stand Jeanne Meadows and I, for how could the bricks and mortar for the building have been accumulated had it not been for, and sometimes in spite of, the efforts of staunch citizens like us. We wanted a community hospital for ourselves and our children badly enough to go out and earn it — by the sweat of our brows, by the chill of our bones, and at the peril of the digestive tracts of uncounted citizens. ■

Nancy Lane is the pseudonym of an author who for a variety of reasons, most of which can be found in this article, chooses to remain anonymous.

(*Continued From Page* 60)

Hard-shelled campaigners contend that only about 20 per cent of the gifts can be attributed to the first two factors.

Important to the administrator will be the personal relationship he will have with the campaigners. At the outset it will be close. As the education and promotional matter is put together and hospital statistical reports are requested many conferences will be held. Determining and pricing of memorials, among other routines, will put them in contact. However, the campaigners prefer a downtown office for several reasons — among them, limited intervention by hospital authorities.

Some directors prefer to hold regular sessions to report progress and problems. Monday morning breakfast with board and administrator is an example.

The more dynamic the director the more likely he is to dislike intervention. It is characteristic of the type of man best qualified to get the money. If the director is *always* the gentleman, *always* has time for the trivial, it is time to consider initiating a request to the firm for a director capable of getting the money (one of those the company has insured for $100,000).

Follow-up on a campaign is essential. Hospitals cannot be built with pledges. Inroads into the final production figure are certain. Conditional pledges are commonplace in campaign-wise communities. Goals are often set high to cover shrinkage. Oversubscription is another means of offsetting pledge mortality. The cost of raising the money, duplications through multiple reporting, natural casualties, and expense of collection, all reduce the funds for construction. Interest from invested collections and a relaxed development effort to obtain more money can help reduce the loss.

A continuing office for collection and public relations interpretation should be formed at the time the divisions get under way. This assures better donor records after the campaign through tighter control of reporting during the campaign. Thorough refinement of the accounts receivable by means of an audit letter is sensible.[3]

Continuing liaison with participating companies is required on payroll deduction pledges to see that employe money is being withheld and that payments are being transmitted on pattern and schedule.

Campaigns that have fallen short can be salvaged. Usually a longer period is allotted than was used originally. Revised plans and actions take up the slack of faults of the first time around.

Can your campaign succeed?

Reliable statistics on campaigns are hard to uncover. Those available are enlightening. One firm kept a record of 228 hospital campaigns from Jan. 1, 1949, through 1955. Combined goals totaled $269,302,860. At the time these statistics were acquired all were not completed. As of July 1, 1953, 153 were announced as oversubscribed to 110 per cent of their combined goals which approached $66 million plus, or roughly 45 per cent of the combined goals of almost $145 million raised.

Unfortunately, today there is a trend toward missed goals — possibly the result of too many campaigns and worn-out leadership. Since it is progressively more difficult to put fund drives over, the day may come when the client will enter into agreement with a second firm or free-lancer to counsel and advise as a "friend of the family." Among responsibilities assigned would be investigation of the assigned director prior to his acceptance, appraisal of the health status of the campaign at periodic intervals, approval of requested service extensions at the end of a campaign, and possibly aid in determining whether the campaign should be put into a moratorium or continued despite an anticipated missed goal.

Most assuredly, relationships are changed by a campaign. The moment one penny is given by *anyone* for hospital construction that donor has placed an obligation on the hospital. The administrator and board at the conclusion of even a successful campaign may feel they knew too little about campaigning at the outset and know too much about it at the end of the service.

Benjamin Franklin started this business in 1750. Now, 209 years later, we are still at it carrying on with the high level code of ethics and service of the fund firms, plus a great deal of volunteer "citizen dedication." Accompanying and bulwarking these factors is our realization that advancing medical and hospital science, expanded hospital use, and institutional nonprofit status have put hospitals in a position from which only private philanthropic dollars can temporarily extricate them. ■

[3]Pledge data usually transferred to ledger cards or held on three sets of pledge cards — morgue, throw and payment set.

These Questions Determine Success or Failure

(If the answer is "yes," the campaign has a chance to succeed. If it is "no," much preliminary work will be necessary.)

1. Is this proposed money raising a part of a comprehensive master plan, or can it become the initial step in a long-range plan of building and sustained giving?

2. Is there available an immediate fund to get the project started via studies, to pay initial contract costs for specialists, and to show the community the hospital is investing its own resources to the extent possible?

3. Is the cause worthy? Does the hospital deserve support based upon past quality service? In short, do we have a case (reasons for giving)?

4. Is the money in the community? If so, is the community "bled white" from recent other philanthropic ventures, or does the proposed campaign conflict with other scheduled money efforts?

5. Is volunteer leadership available and sufficiently big in "recognition stature" to provide the necessary inspiration and maturity?

6. Is the need really existent? (Need is a relative term which has the disturbing trait of seeming greater to us than to others.)

7. Have we done everything possible to take care of the problem ourselves?

8. Do we feel the importance of the project overrides the risk taken, *i.e.* the implied obligation to future "partner-relationship" with the community in exchange for its help now?

Case History of a Successful Campaign in a Small Town

LAST summer a shabbily dressed man peeked in a window on the main street of Superior, Wis., hesitated, then timidly opened the door.

Walking up to the desk of Henry R. W. Knudsen, worn hat in hand, he asked the Wisconsin industrialist if this was the office where they were accepting contributions for the proposed 100 bed hospital.

When Mr. Knudsen assured him he was in the right place, the man reached in his pocket and pulled out a $20 bill. Laying it on the desk, the man told Mr. Knudsen he didn't have much money because he was on a pension.

Then into the frayed pocket again, and out came another $20 bill with the comment that there certainly should be a new hospital in the community of 35,000 persons. Twenty minutes and several comments later he walked out the door, and the hospital was $100 nearer to realization.

That pensioner typified the spirit that raised more than $1.2 million in a city of 35,000 persons. This is one of the largest amounts ever raised in a city of that size in this country, according to fund raising officials.

Here's what happened.

During 1955 the board of directors of Superior Memorial Hospital decided to solicit funds from foundations, wills and trusts. A nonprofit organization was incorporated for that purpose. The next year a formula was drawn up to sell hospital association memberships, ranging from $25 for a regular membership to $1000 for a life membership. A women's auxiliary was formed, and grew to more than 1500 members. They held cake sales, rummage sales, white elephant sales, and placed money cannisters in stores. A special appeal was made to the large foundations for help in building the new hospital. Year-end giving was promoted among the businesses in the area and individual gifts were stimulated.

But results were poor. All of these methods produced little money, and the community became discouraged.

Mr. Knudsen, the spark plug of the fund raising project, analyzed the program. He was not pleased, but he was far from discouraged with the efforts expended. He felt there was not enough of a planned campaign – an organization was needed, he reasoned,

Okey Swisher, director of the general gifts division, explains campaign activities to a group of women volunteers. Before him are pledge cards and campaign literature.

Thermometer was a main symbol of the campaign. Here the German band plays beneath the sign in Superior.

The Efforts of 35,000

to give experienced direction to the campaign.

Several firms specializing in fund raising were invited in for interviews and to make presentations.

One of them was selected to make a preliminary survey to determine if the community could raise enough money to equip a 100 bed hospital, which was the size of the facility as recommended by the Wisconsin State Board of Health.

Nearly 90 per cent of those interviewed in the survey felt the proposed hospital would attract needed specialists to the area. One prominent doctor pointed out in the interview, and later stated it publicly in a story given wide publicity, that he had personally persuaded three pediatricians to come to Superior to practice, but that each one of them later left because of the lack of facilities and opportunity. Business and industry leaders foresaw the institution as important in attracting industries to Superior.

There were 87 per cent who stated a definite need for the hospital, an-

Here the board of directors of Central Cooperatives, Inc., signs a $30,000 pledge card. Labor and management both joined the drive and encouraged plant solicitations.

Stores vied to present the hospital story in the most dramatic manner. This display uses mannikins and streamers to posters explaining medical care costs.

Citizens Added Up to More Than a Million Dollars in Contributions

other 8 per cent who felt no strong urge one way or the other, and, as usual, a group of 5 per cent who were opposed definitely to building the hospital.

But when the fund raising firm told the executive committee of the hospital that $750,000 could be raised, it nearly didn't get the job. It seemed impossible to raise that much money from 35,000 citizens.

Mr. Knudsen, however, had confidence. The campaign counselors were retained to do the job – at a flat fee, which was their normal method of operation.

One point that was determined early, before the campaign work began, would be of special significance to many hospital planners. The Superior board was concerned because it had not developed architectural plans in advance of the money raising activities. The fund raising firm supplied government approved, standardized plans which were subject to local revisions after the money was in. Now the trustees have money on hand and the building can be planned with the money pledged instead of raising enough money to build a hospital that has been designed without regard to fund raising potential.

Three men were assigned to the new Superior hospital by the fund raisers. The survey had disclosed a need for a precampaign program far in advance of any campaign for funds. This included campaign leadership development, prospect listing, and public relations and publicity activities.

Members of the hospital association held parlor meetings in their homes and invited the business and civic leaders of Superior. Mr. Knudsen and the fund raising counselors informally led discussions of the hospital need and how to enlist the best possible leaders.

The groundwork was solidified. The influential leaders, those sources of campaign leadership so necessary for this type of project, were subtly recruited.

Committees – active committees – worked hard to keep the campaign going.

The entire board, along with many others, became members of the sponsors' committee, a prestige group to make every leader – civic, business, labor or religious – keenly aware of the campaign forthcoming and to enlist active participation by contributions and solicitations.

After several months of preliminary work, the campaign was ready to move. The goal was defined, the plan of attack was rehearsed during the maneuvers, and all that was necessary was a spectacular frontal attack to key the drive.

Campaign headquarters was established at the busiest intersection in the city. Clerical office personnel was hired and trained. The professional fund raisers had made a careful study of the proper method to make the appeal and of potential contributors, and were getting acquainted with the citizens.

Operational plans were formulated.

(*Continued on Next Page*)

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A hospital board meeting was called and the plan was detailed to it. The counseling team showed how many leaders were needed and how to recruit them; how many gifts and in what amounts; the number of workers needed to make a personal call on every prospect; and how they were to be recruited and trained. A publicity calendar was presented and prospect evaluation systems and an industrial giving formula were offered.

Pace setting gifts were obtained through the major gifts division. The first three gifts were for $55,000, $50,000 and $45,000, with others of comparable size.

This set the pattern of giving at the top and helped the campaign open spectacularly.

Prospects Asked To Invest

While the organizational phase was being completed, the prospect evaluation group was combing through its cards and estimating the amount to be asked from each prospect. It was suggested that the prospect be asked to invest in the hospital, not give to the hospital.

Then came the public information dinner to show how excellent were the chances of a successful drive.

Mr. Knudsen told of his hopes for the hospital; a lawyer discussed the need for additional beds; a doctor spoke on the medical aspect of the new hospital; another lay leader spoke of the fund raising and the necessity for everyone to do his part.

Then the bombshell.

Major gifts and pledges of $112,000 were announced. The people, and there were several hundred present, realized that 15 per cent of the goal of $750,000 was already raised.

This was a tremendously heartening sign for the community.

The next morning things began to happen. The surrounding towns, which, of course, would also benefit by the hospital, were set up as an "allied towns division." This division later produced 90 per cent participation by those townspeople, and drew the individual communities much closer together.

Another dinner was held for labor leaders, who boosted the efforts and pledged support, encouraging in-plant solicitations and payroll deductions for pledges. It was the first time in Superior's history labor had actively taken part in any drive in the community. It resulted in bringing labor and management together in a united effort.

To add excitement to the campaign, a huge thermometer was constructed on the facade of the post office building in the heart of the downtown shopping district. The first time the sum of money collected was painted on the thermometer, the red column reached to $361,000. This was only the first month of the campaign. On hand that night and every night that results were posted was the "German band," a favorite in Wisconsin. Interest in the campaign caused merchants on the main street to complain jokingly that the ceremony was costing them 30 minutes of lost business because of the crowds it attracted.

Children Helped, Too

Lemonade stands sprang up after one enterprising youngster, whose father had recently died, opened a stand to sell lemonade, bubble gum, used comic books, and what have you, with a sign reading "Help Build the New Superior Memorial Hospital." By noon of his first day's operation, he had collected $3.86, and soon stands blossomed throughout the city and neighboring towns.

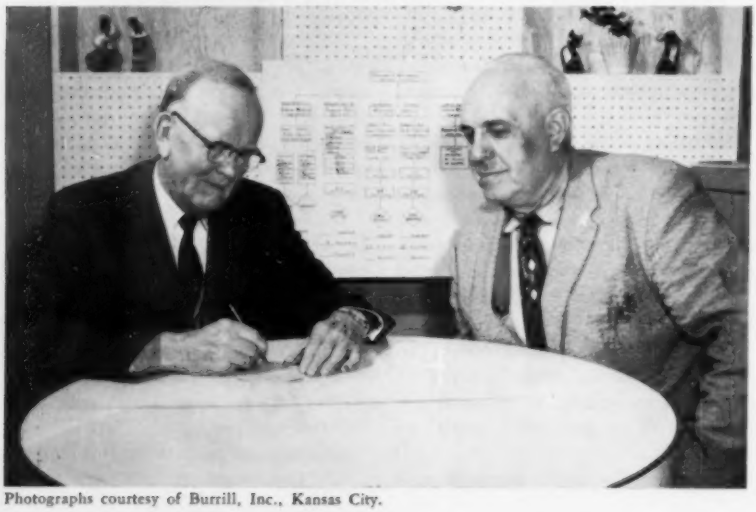
Stores gave window space, with one window display showing mannikins dressed as a doctor and a nurse at a child's bedside, with bright ribbon leading to signs on the windows and backdrops indicating the number of hospital personnel required to take care of a patient.

A speakers' committee at times averaged 15 talks per day before civic clubs, fraternal organizations, and plant workers. Dozens of talks were made in the roundhouses of railroad yards, in the shipyards, and even from the tailgates of trucks on jobs.

Persons became so interested in the campaign they began to offer testimonials on the near brushes with death they had experienced owing to the lack of facilities. Merchants were making bets up and down Main Street that the goal would or would not be reached, and then those that bet against the success of the campaign found themselves being talked into contributing money to help meet the goal. The profits from vending machines in one factory were pledged to the hospital fund for the next three years.

Walk down the streets of Superior today and you find a proud city. And with some justification. The final total of more than $1.2 million exceeds the amount raised for hospitals in many larger areas. ■

Victor Nelson, left, Wisconsin contractor, signs a pledge card for $45,000. With him is Henry R. W. Knudsen, Wisconsin shipbuilder and chairman of the board of directors of Wisconsin Memorial Hospital who had given $55,000. The hospital was $100,000 nearer completion when they got through.



Photographs courtesy of Burrill, Inc., Kansas City.

Ten Sure Ways To Defeat Any Fund Raising Drive

Here is a list of mistakes that are just about guaranteed to wreck a fund drive, sometimes before it even gets started

EVERYBODY makes errors in fund raising, but many of them are avoidable. Here are 10 such errors, presented first as quotations and then analyzed and discussed.

Error No. 1: Unethical Practices

Let's hire a fund raiser on a percentage basis. First, this will assure us of a fixed, substantial percentage of income. Second, the fund raiser will have more incentive.

Such an approach is not only professionally unethical, it is also ineffective.

If it is known – and it invariably is – that a professional fund raiser is to receive a stated percentage of every dollar, this arrangement discourages giving, no matter how modest the percentage may be.

Error No. 2: Averaging

Our building will cost $300,000. We have 3000 constituents. All we need is $100 from each.

This approach is also known as "building hospitals by the multiplication table." It's a subtle error. And a dangerous one because it seems so plausible. Its fallacy lies in the obvious fact that thousands of people don't give the same, uniform amount. They also vary in their ability to give. A prospect often gives soul searching thought to the kind of gift he will make. Often, the giving potential of fellow donors enters his considerations. As Maimonides pointed out, one of the highest degrees of giving is "giving proportionately, according to one's means."

It does not seem fair or sensible to ask the $8000 a year man for the same donation as the $50,000 a year man. And worse, a blatant case of undergiving may demoralize a campaign just as surely as an example of proportionate giving may inspire it.

Error No. 3: Laziness

There are plenty of generous people. They give several billion dollars a year. Why don't we get a list of generous contributors? Send them a good, appealing letter, signed by a big name. That'll get the money.

For all its frail impracticality, this notion seems to strike with force. Trouble is, money is raised much as sales are made – by making calls. Not by writing letters.

Mailing in quantities is costly. A thousand letters will cost more than $100. And letters cannot be warm or personal. Nor can they be urgent, or take the place of personal calls.

Don't write for solicitations if you wish your hospital campaign to be taken seriously. A written solicitation is a lazy one. And a lazy effort produces a lazy response.

(*Continued on Next Page*)

Adapted from material prepared by Joseph Samuels, Sklag and Company, New York fund raising firm.

(*Continued From Preceding Page*)

Error No. 4: Glibness

Just get plenty of publicity, that's the main thing. If people read about the worthiness of our project, they'll give.

Wishful thinking!

To many potential contributors, at least at the outset, a hospital fund raising campaign is just one more worthy cause. Publicity alone will not win them over.

A newspaper release usually sounds fine to those who sponsored it. Even persuasive. After all, they've read it. And they were already convinced and sympathetic. But what about the man who is not already convinced? And the man we are trying to reach precisely because he is not interested? Publicity will help inform these people, most certainly, but it cannot effectively replace face-to-face solicitations where questions can be answered and problems resolved.

Error No. 5: Oversimplification

A fund raising campaign is, after all, a collection. All we need are some good collectors.

This is like saying that farming is, after all, only harvesting. The collection is only one phase of a successful fund raising campaign. In itself it is not a campaign. Without proper timing, the collection can come too soon or too late and lose much of its effectiveness. Behind it must be a working timetable, daily reports, and a coordinated effort.

Error No. 6: No Teamwork

A fund raiser should raise money from his own contacts.

This error rises from an unawareness of the role of fund counsel and the responsibility of hospital trustees.

In fiscal matters, the board has a dual responsibility: to raise money and to spend it. Given a choice, most trustees would appear to prefer the spending rather than the collecting process.

Fund raising is mistakenly considered to be more difficult than fund spending. If there is a reduction in funds, many trustees become more concerned with reducing program than with increasing income. Consequently less money is raised and less is spent, a development that hinders the effectiveness of the hospital to the community it serves.

Teamwork with competent fund counsel can reverse this trend. Fund counsel solicits with the trustees, not in competition with them. Together they establish the giving pattern.

A fund raising saying goes, "Three-fourths of the task is to ask." A corollary adds, "Two should do the asking."

Don't destroy teamwork. Build it. Don't work separately. Work together with fund counsel. It's not merely pleasanter. It raises the money needed by the hospital.

Error No. 7: Parsimony

Counsel fees are too high. There must be a cheaper way to raise money.

It takes money to raise money. Fund counsel fees are low for they are wisely invested in success. On the other hand, money spent in failure is wasted.

False economy, addressed to the fee, betrays a lack of knowledge of the true cost of fund raising. By seeing only the fee, a committee shops by price tag. Such a committee often sacrifices competence to economy.

An ill advised committee can easily blunder into one of two errors: the do-it-yourself committee or the hiring of a boy to do a man's job.

Error No. 8. Defeatism

We have no wealthly people. So no fund raiser can help us raise enough money for new facilities. It will take years to raise what we need. Let some other administration do it. Maybe by then we'll have a stronger board.

The wealth of the constituency is not nearly as relevant to its fund raising potential as might be supposed. Other factors can and do contribute much more to success than the mere wealth of the membership.

Complacency or fear can defeat a fund raising program quickly.

A willing giver of $100 is worth more to a hospital campaign than a determined noncontributor worth $1 million.

Success has been won by a sincere open-minded desire for it on the part of the board. With such desire, and a willingness to work for a successful campaign systematically, professional consultation and management will often succeed in areas where the potential appears to be hopeless.

Error No. 9: Temerity

What's all this about prerequisites and essentials? There's a need for money, that's all we need to know. Now, let's go get it.

No responsible fund raising consultant will permit a campaign to start without adequate preparation. Four essentials are needed:

1. A truthful case, well told; one that will convince and inspire.
2. A chairman who leads and works closely with fund counsel; one who will help enlist workers and inspire their participation.
3. Workers who work and follow their chairman; workers who will visit prospects.
4. A constituency which favors the achievement of the campaign's objective.

If you don't have all of these essentials, don't start a campaign. Consult counsel as to ways of acquiring them.

Error No. 10: Omniscience

We don't need a plan or survey at our hospital. Everybody knows what we do. Those who don't aren't interested.

Who *really* knows the fine job being done at most institutions, except for the few insiders — the "family" — those who work faithfully and attend board meetings. How many board members can speak knowledgeably about the work of the hospital? Those who can are often too close to the project to see the selling points of a fund raising campaign the way, for example, public relations or fund raising counsel can.

What is needed in most fund raising campaigns is a brief or brochure that tells in digest form the essence of the "case" for a hospital. It tells why the hospital needs money, how much, how it will be spent, and how one can help. Such a brief is best developed through research. An untested brief is usually an unproductive one. It is usually prepared on a guesswork basis. Without interviews. Without a fund raising analysis.

Don't draft a sloppy brief. It can foredoom your campaign. ■

The Modern Hospital of the Month

Services That Go Together Are Together on This Plan

CENTRALIZATION of services is the key to efficiency at the 220 bed St. Michael Hospital, Milwaukee, where three major areas have been grouped to provide a free flow of services within and between departments. These are: central food service on the ground floor; the surgical patient area on the second floor, and the outpatient diagnostic and treatment center, also on the ground floor.

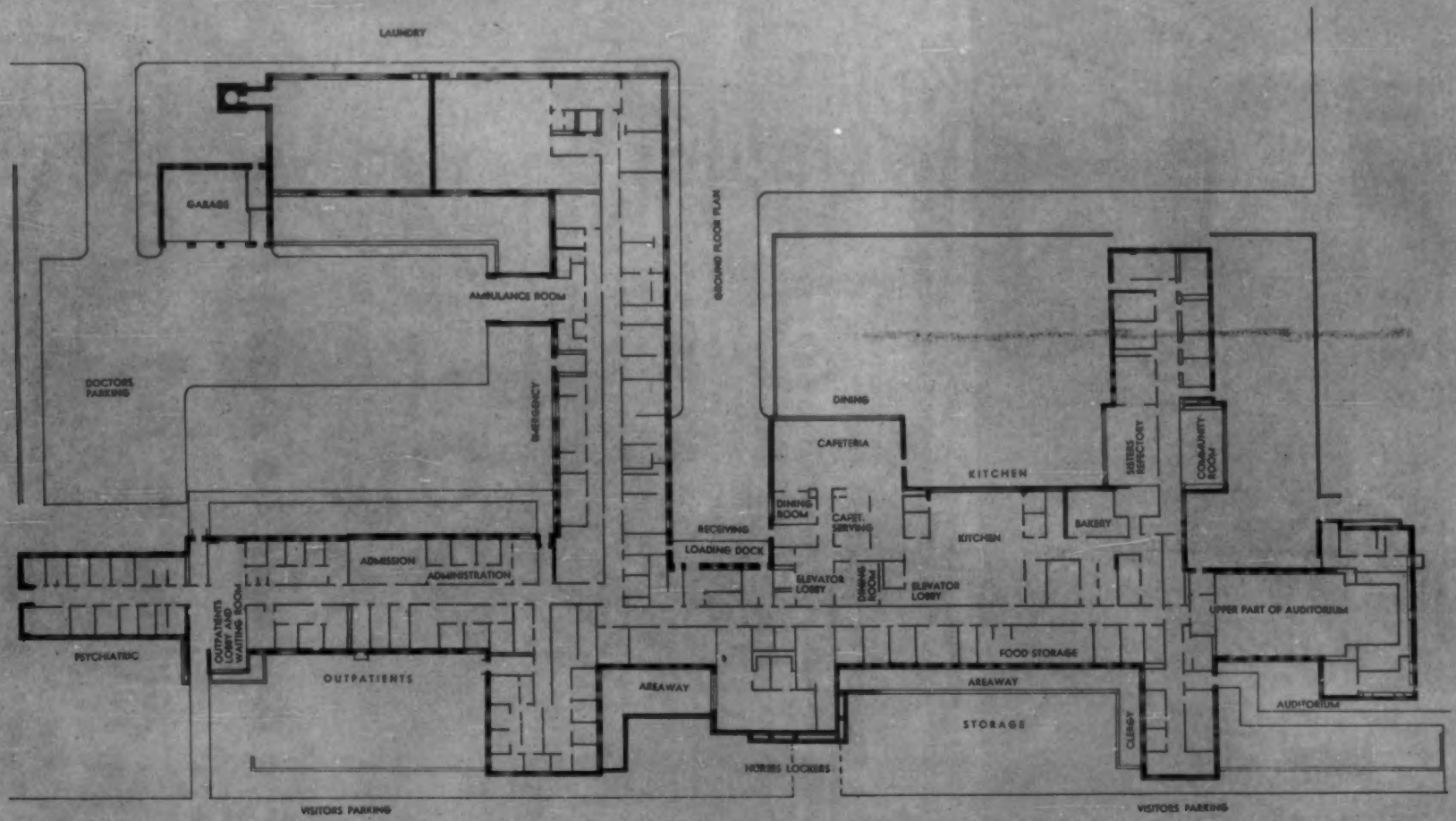
Of special pride to both Sister M. Jeanne, administrator of St. Michael, and the architect, Ralph P. Ranft of St. Louis, is the food service department. From the kitchen located in the center of the building, service radiates in three directions: to the hospital proper, to the employes' cafeteria, and to the Sisters' dining area in the convent section of the building.

The tray assembly area, Sister Jeanne explains, is planned to provide for the greatest flexibility of service. Trays can be sent to the floors by conveyor, dumb-waiter or in heated food trucks. Ordinarily, food is sent to patient floors on dumb-waiters which have no shelves and open at floor level. They are built to accommodate small carts which hold four trays each.

The carts are loaded at the tray assembly belt and put in the dumb-waiters; they can be rolled off at the floors and taken directly to patients' rooms. Thus loading and unloading of dumb-waiter shelves has been eliminated. Soiled dishes are returned to the dish-washing room on the conveyor. A special elevator equipped with electric outlets, and reserved for the sole use of the food service department, will permit the present method of service to

(*Continued on Page* 72)

View of St. Michael Hospital, Milwaukee, from the side. Exterior is brick laid in Flemish bond. It gives the walls a decorative effect without being startling.


LAUNDRY
GARAGE
AMBULANCE ROOM
GROUND FLOOR PLAN
DOCTORS PARKING
EMERGENCY
DINING
CAFETERIA
KITCHEN
SISTERS REFECTORY
COMMUNITY ROOM
DINING ROOM
CAFET. SERVING
BAKERY
KITCHEN
RECEIVING
LOADING DOCK
ADMISSION
ADMINISTRATION
ELEVATOR LOBBY
DINING ROOM
ELEVATOR LOBBY
UPPER PART OF AUDITORIUM
OUTPATIENTS COMP. AND WAITING ROOM
PSYCHIATRIC
OUTPATIENTS
AREAWAY
FOOD STORAGE
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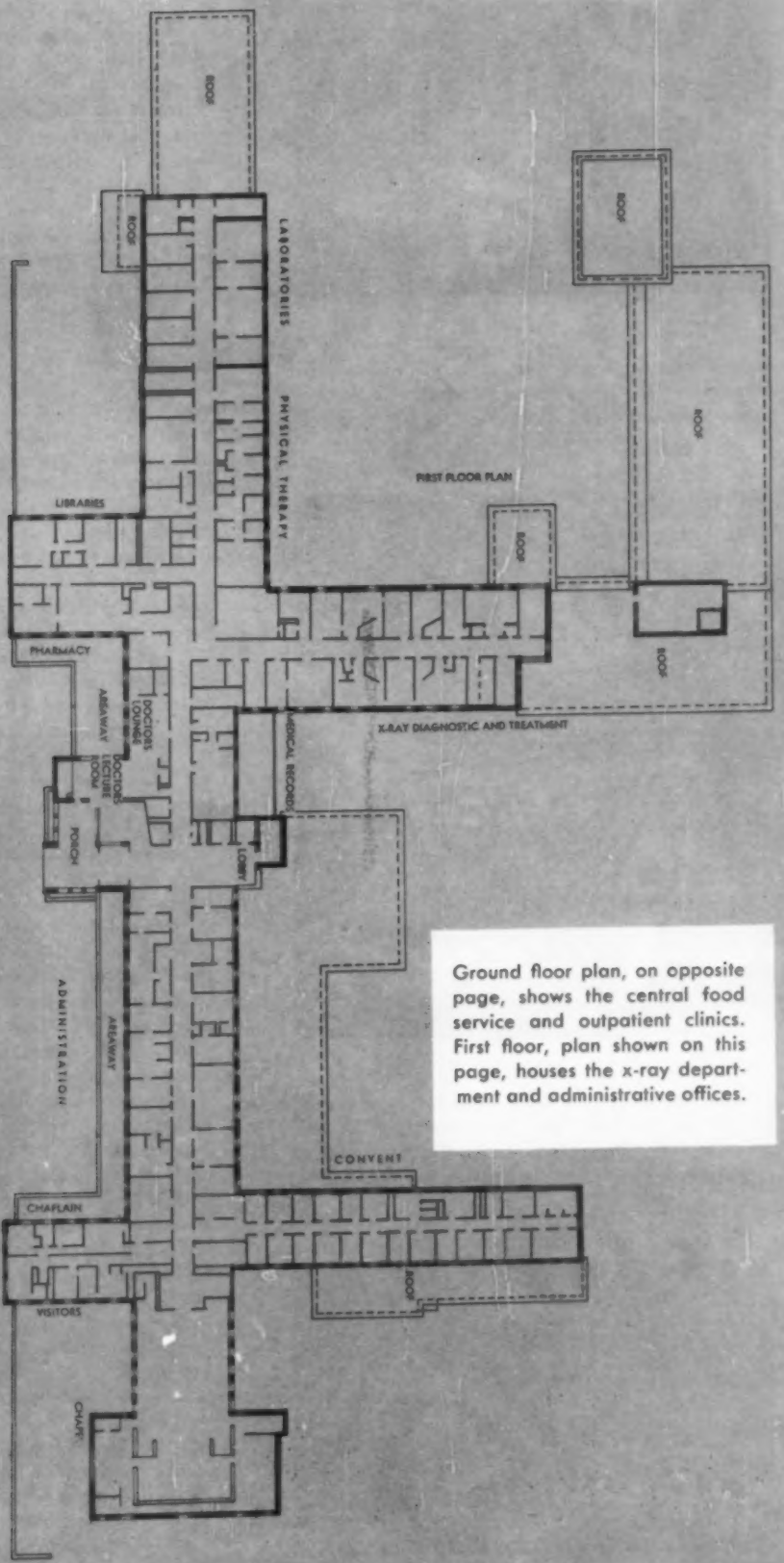


Ground floor plan, on opposite page, shows the central food service and outpatient clinics. First floor, plan shown on this page, houses the x-ray department and administrative offices.

Patient rooms are arranged so as to provide view of adjacent park from bedside window. A built-in dresser and wardrobe is provided for each patient.

Above: Tray assembly area provides flexibility of service for tray conveyor, dumb-waiter, or heated food trucks. Below: Session in the occupational therapy room equipped for various learning needs.

(*Continued From Page 69*)

be switched to service by hot food trucks should such a change become desirable.

Everything that pertains to surgery, from the patients to the recovery room, is housed on the second floor. The purpose of this arangement, Sister Jeanne states, is to eliminate the use of elevator service to and from surgery and the recovery room. The patient area is separated from the operating rooms by the central supply.

Designed to accommodate a patient load of 60,000 visits annually to the various clinics, the outpatient diagnostic and treatment center occupies the west wing of the ground floor. Laboratories, x-ray service, and the pharmacy are located on the first floor directly above this area so that outpatient traffic is kept out of inpatient areas as far as possible.

Elimination of cross-traffic was a major concern to both the Sisters and the architect, Mr. Ranft points out. Most of the services are dead-ended and located on the floor to which they are particularly related. Elevators and stairs were placed with this in mind so that it is unnecessary for either patients or personnel to use one department as a passage to another.

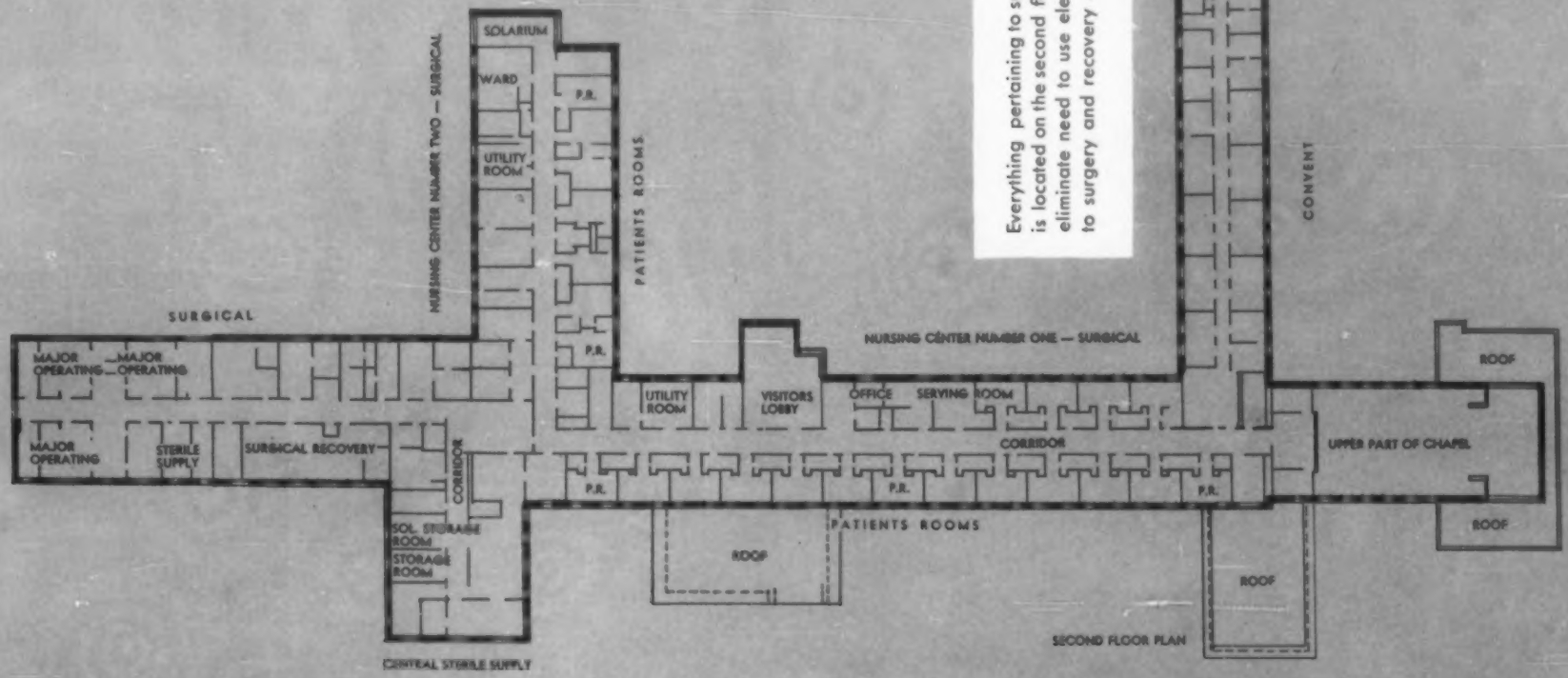
One entire floor, the sixth, is designed for neuropsychiatry. It contains both open and segregated sections, treatment and recovery rooms, and recreational and occupational areas.

The pediatrics department is an enclosed unit, with nurseries, wards, isolation sections, observation rooms, and playrooms. The murals in the playroom (shown in color on this month's cover) are the work of Kurt Rueping of Milwaukee and were donated by Dr. Joseph Vaccaro, head of the pediatrics department. In the murals the artist attempted to create a dreamland to stimulate the imagination of children, Sister Jeanne explains.

A chapel notable for its paneled walls, stained glass windows, and marble floor is available for those who wish to use it. The pews are arranged to seat two persons each so that each one sits on an aisle. Below the chapel is an auditorium for large assemblies.

The exterior of the hospital is brick laid in Flemish bond, which gives a texture to the wall that adds to the decorative effect although it is not startling or theatrical, Mr. Ranft states.

(*Continued on Page 74*)


Everything pertaining to surgery is located on the second floor to eliminate need to use elevators to surgery and recovery areas.
SURGICAL
NURSING CENTER NUMBER TWO — SURGICAL
SOLARIUM
WARD
UTILITY ROOM
P.R.
PATIENTS ROOMS
NURSING CENTER NUMBER ONE — SURGICAL
CONVENT
MAJOR OPERATING
MAJOR OPERATING
MAJOR OPERATING
STERILE SUPPLY
SURGICAL RECOVERY
CORRIDOR
UTILITY ROOM
VISITORS LOBBY
OFFICE
SERVING ROOM
CORRIDOR
UPPER PART OF CHAPEL
ROOF
ROOF
SOL. STORAGE ROOM
STORAGE ROOM
PATIENTS ROOMS
ROOF
ROOF
CENTRAL STERILE SUPPLY
SECOND FLOOR PLAN

Right: A nursery on pediatrics floor. Playroom mural is shown on this month's cover.

OUTLINE OF CONSTRUCTION COSTS

Total project cost (including fixed equipment and landscaping)		$6,220,000.00
No. of beds (planned for 30 additional)	250	
Cost per bed		29,545.00
Total square feet	305,000	
Square feet per bed	1,363	
Cost per square foot		20.30
Total cubic feet	3,605,000	
Cubic feet per bed	16,500	
Cost per cubic foot		1.72

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital and the architects. A similar award will be made each month.

Operating section and patient areas are separated by this strategically located central sterile supply department.

SPECIAL FEATURES THAT PLEASE THE ARCHITECT

Among the noteworthy features of the design of St. Michael Hospital, described on the preceding pages, Architect Ralph P. Ranft mentioned the following:

1. There are no steps at any of the entrances. Even the customary riser at the main door is missing.

2. There is plenty of storage space. The Sisters insisted on it, pointing out that the search for adequate storage areas in many hospitals necessitates costly alterations or additions that could have been avoided had this important space been included in the original plans.

3. The elevators are so located that none of them discharges directly into a patient area. This not only eliminates noise and gives the nurses good control of traffic, it also serves as a fire safety measure. Because of this feature, it was not necessary to provide smoke screens because patients can be moved from one section to another if the occasion arises.

4. Economy of design, consistent with the type of service to be rendered, and economy of maintenance were the watchwords of the hospital officials in planning the building. This has resulted in a low unit cost per square foot even though the cost per bed is somewhat higher than usual because of the inclusion of convent, chapel and the large outpatient department in the layout. ■

Key factors in infection control are indoctrination of personnel and close supervision of admissions

Physician Outlines Infection Control Plan

DALLAS. — A practical program for the control of hospital infection was described here last month to physicians attending the clinical meeting of the American Medical Association. Dr. Ian Maclean Smith, associate professor of internal medicine at the State University of Iowa College of Medicine, emphasized that the program he described applied to all kinds of cross infections.

"Time, money and effort are all required before control can be achieved," Dr. Smith said. "There is no single answer to the control of staphylococci in hospitals. The measures used apply to other cross infections, which will surely plague us should we deal with the staphylococcus only."

Indoctrination of hospital personnel is essential in an effective infection program, Dr. Smith said. All personnel should receive indoctrination, he added, recommending use of slides or moving pictures, with each department responsible for its own inservice education. Key personnel in physical therapy, laboratories, electrocardiography and other departments can attend nursing lectures and transmit information about infections to their own departments, he suggested.

The material may also be presented in a hospital handbook, Dr. Smith added. "It is advised that amateur, untrained personnel be discouraged from volunteering to work in the wards of a hospital," he warned.

Close supervision of admissions is another key factor in the control of infections, Dr. Smith reported. Admission diagnoses should be reviewed by a member of the staff in internal medicine, he recommended, and the appointed staff member should also make a brief examination of the patient. "Undiagnosed febrile patients should be isolated until a diagnosis is established," he said. "In addition, the head nurse on each ward should be free to isolate a patient on suspicion of infectious disease being present."

Since it takes about ten days to acquire nasal carriage of the prevalent type of staphylococcus infection, Dr. Smith suggested, patients admitted for elective surgery should come to the hospital immediately before the operation.

The infection committee should include the administrator and housekeeper as well as representatives of the medical departments, it was suggested. The committee should meet at least once a month and keep records, he added. "Money must be provided for the expenses of such a committee for data collection, bacteriological surveys, educational and clerical duties."

The first function of an infection committee is to obtain factual information regarding the infection problem in the hospital, Dr. Smith pointed out, and such information can only be obtained by an inspection of the wards. "All patients in the hospital are visited by a physician and the head nurse," he reported. "Boils, carbuncles, breast abscesses, impetigo and osteomyelitis can be accepted as being caused by staphylococci. It is important to realize that this problem is hospital-wide and that infected personnel cannot be shuffled from service to service."

Detailed reporting is an important part of the system described by Dr. Smith. A monthly report is sent to the head of each department listing the number of infections on the service that were cultured and found positive for staphylococcus during the current month, he explained. The report also shows the number of infections for the last three months, and the same month the previous year.

"If the first (current) figure exceeds the following two, then details of all patients with infections are included in the report," Dr. Smith explained. "This acts as an epidemic warning system, and each service is free to control it as they wish."

The notification system can be emphasized and used for teaching personnel by tagging all charts of patients with infections with a red mark, Dr. Smith suggested.

The Iowa system includes follow-up reporting by telephone or postcard, it was explained. Such follow-up reporting has been criticized by some, Dr. Smith acknowledged, but hospitals using it now consider it a good public relations measure. "No reporting service can be considered adequate without it," Dr. Smith declared. "In certain of our larger towns we have interhospital infectious disease committees, and in one city the public health office takes part. Follow-up reporting by public health and visiting nurses is frequently beneficial. As part of the committee's initial survey, all women delivered in the hospital during a given month should be called on the telephone two months later."

Other measures included in the Iowa program, as reported by Dr. Smith, were:

1. Reinstatement of the authority of the head nurse. The head nurse wears a distinctive uniform so that all are aware of her authority. She should

be free to report other personnel, including physicians, for lapses in isolation technic to the chief of the service, and free to institute isolation measures on suspicion of infection. Nursing personnel should attend ward rounds. Nurses assigned to delivery rooms and the newborn nursery should not be interchanged with other services.

2. Rigid enforcement of handwashing technic. A survey of handwashing facilities is essential. Clerical and other rooms adjacent to wards may be used for isolating patients, if handwashing facilities are available. Posters in staff areas may help reinstate the habit of handwashing between patients. Taps should always be considered clean. Paper towels should be used in turning them on and off.

3. Isolation of infected patients and personnel. Ten per cent of beds in internal medicine and pediatrics should be usable on an isolation basis, with proportionately fewer beds needed in the other services. A portable isolation cabinet maintained by the housekeeping department, containing gowns, masks, stethoscope and sphygmomanometer, is useful to institute isolation. Control must be maintained on infected personnel, who should be permitted to return to duty only on recommendation of the designated personnel health physician.

4. Maintenance of adequate bacteriologic facilities. Neglect of medical bacteriology in the hospital has been too widespread. In smaller hospitals, the provision of adequate bacteriologic facilities is a first order of business. Bacteriology cannot be practiced in total separation from clinical medicine. "The time is right for a revival of medical bacteriology."

5. Antibiotic regulation. Policy should be established for use of antibiotics throughout the hospital. Routine administration of antibiotics to "clean" patients is dangerous; use of antibiotics to cover clean operations should be banned. "It is preferable that all antibiotic orders should be written for a prescribed interval, so that patients do not receive antibiotics merely because a discontinue order has not been written."

6. Wound dressing technics. If a special room for wound dressing is not available, the ward (patient's room) door must be closed and the ward kept quiet when dressings are done. Wound dressing is a two-person operation and both must wear gloves and masks which cover the nose. Individual dressing trays supplied by central supply are recommended. The "ritual application of dressings at stated intervals" is hazardous. "If the wound is painless and the patient is comfortable and afebrile, there is little need to change a dressing until the stitches are removed."

7. Traffic control. "Just as factories and atomic plants have areas of limited access, so should a hospital. Obviously, operating rooms and suites should be closed to the general and medical public, but they should also be locked at night and cleaned only when the head nurse is present. Doctors should never enter a newborn nursery but should be handed the baby in his bassinet over a Dutch door. Various areas of special interest or even wards should have a bell at the door so that patients or drugs may be brought to the door to prevent the ward becoming a mass thoroughfare."

The administrator can be the most important person in the hospital in the control of infection, Dr. Smith concluded. "Your costs are too low if a significant number of staphylococcal infections are acquired in your hospital," he said. "Medico-legal experience will soon prove this point. We have previously shown that the cost of infection to the hospital and to the patient is double that of the uncomplicated disease. Money should be provided for locker space so that hospital clothes are not worn outside.

"Regular cleaning schedules in all areas are necessary, and the closing of certain areas for thorough cleaning might be considered. Wet mopping with a bactericidal agent is much preferred over dry mopping. Wall washing with a bactericidal agent is necessary for terminal disinfection." ■

Forand Bill Is Opening Maneuver To Bring Federally Controlled Medicine, A.M.A. Told

DALLAS. — The proposal to add medical and hospital care benefits to social security coverage of the aged was described as "the most important crisis American medicine has ever faced" in an address to the American Medical Association's House of Delegates here last month.

"The Forand Bill is the opening maneuver in a scheme to bring federally controlled medicine to the United States, step by step," said Dr. Louis M. Orr of Orlando, Fla., A.M.A. president.

"It is only the needy and near needy aged for whom financing mechanisms for health care must be improved," Dr. Orr said. The need should be met primarily at local community and state levels, he added.

"Expansion of O.A.S.D.I. as recommended by Mr. Forand would not help the needy, since few would be eligible for such benefits," he continued. "On the other hand it would have a catastrophic impact on voluntary health insurance for those over 65 who want and can purchase coverage. In short, the Forand approach to financing health care of the aged does not meet the need where it exists and destroys progress where it is being made."

Dr. Orr urged members of the House to "do everything within your power and influence to see that the orientation program on the Forand Bill is carried out vigorously." No matter how limited or diluted a version of the bill might be enacted, he said, "we know that it would be simply the first step toward the evolution of a system of national compulsory health insurance for the entire population."

The responsibility of the American Medical Association is not simply to defeat undesirable legislation, Dr. Orr acknowledged. "I charge you with the responsibility of seeing that your state and county societies are carrying out a vigorous, imaginative program with respect to aging and health care of the aged," he said.

Dr. Orr reported that 33 Blue Shield plans in 31 states now enroll persons over 65 years of age. Nineteen plans in 13 states are in various stages of developing special health insurance programs for older people. In addition, 62 insurance companies now offer insurance coverage for persons 69 years of age or older. Forty-three per cent of the population over age 65 is now covered by voluntary health insurance contracts, and it is estimated that 60 per cent of this group will be covered by the end of 1960. ■

This Study Matches the Nurse to the Job

The study reported here helps determine the qualities needed for various nursing responsibilities and thus can serve the hospital as a guide in assigning nurses to the jobs for which they are best fitted by training and temperament

Keith Van Allyn, Ph.D.

WHAT are the qualities and qualifications of a really good general duty nurse? Of a fine head nurse? What sort of person must she be and how does the general duty nurse differ from the head nurse?

Two studies conducted recently revealed some interesting data that may help to answer these questions.* One of them involved 117 registered nurses throughout the country; the other was carried out in three Los Angeles hospitals and included 63 head nurses. Both were made in an effort to determine the qualifications that make for success in the nursing profession.

Careful Evaluation Needed

In common with many other hospitals, the three Los Angeles hospitals have a major problem: a shortage of nurses and a high degree of turnover among nursing personnel. In turn, this places an extra burden on the head nurses of these institutions. It means they have to be especially careful about seeing that nursing procedures are carried out correctly, evaluating the capabilities and work performance of new nurses, promoting their professional growth and development through counseling, assigning new personnel to tasks suited to their abilities and training, designating charge nurses, and so on.

Under these circumstances, it becomes more important than ever to gain a thorough understanding of the background and training necessary to achieve success as a head nurse, and to have this information in a clear and usable form. This applies not only to head nurses and registered nurses but to all other classifications of hospital personnel. It serves as a guide for the basis of selection and training of candidates suitable to the hospital.

Our previous studies of individuals in business and industry, in order to determine causes of labor turnover, accident proneness, and so on offered a sound approach to the problem. These were based on a questionnaire designated as the Qualifications Record, or Q/R.

It is not a test but rather an objective method of eliciting and collating essential information about the qualifications of a person. It does this by analyzing a person's responses in 45 separate categories, or elements, which are considered significant vocationally. These elements are weighed in terms of seven basic factors: interest, activity, ambition, training, experience, achievement and behavior. The resultant pattern clearly reveals the person's qualifications for different fields of endeavor, including nursing.

By submitting the Q/R to all of the registered nurses identified as "superior" by a hospital or clinic, it was possible to develop a composite study, or "job standard," that revealed the qualifications which make for success as a nurse. *Our studies have shown that, on the average, 95 per cent of the superior nurses doing the same type of work have significant traits in common, such as interests, hobbies and education. At present, the only consideration has been the academic background and credentials.*

This technic offered a practical solution to the problem of identifying the qualifications of a superior nurse. Accordingly, several participating hospitals administered the Q/R to their personnel with a substantial record of success in this work.

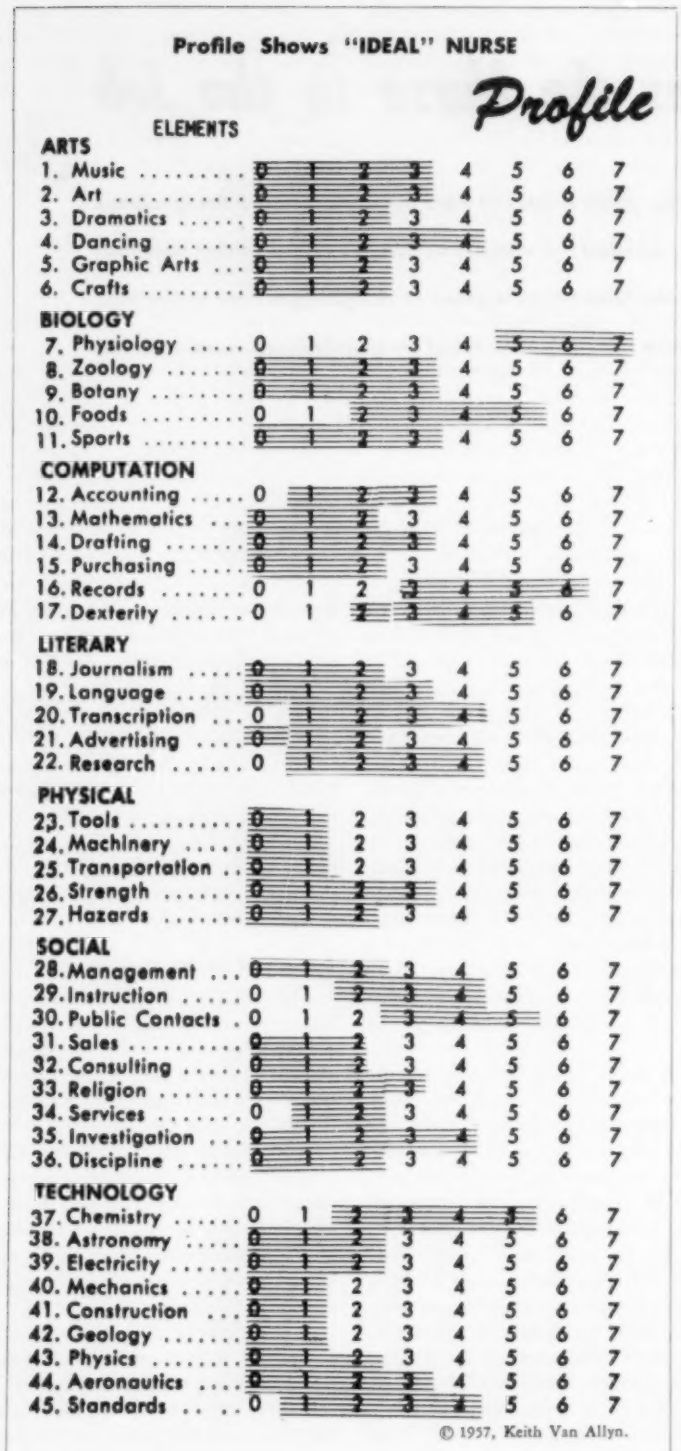
Range of Skills Indicated

The completed Q/R forms were then returned for analysis of the data and development of the job standard shown in the accompanying illustrations. The profile indicates a range of capabilities and limitations from 0 to 7 according to reponses to the Q/R. An "0" degree rating (recessive) indicates that the person has a trait in which she has no qualifications, while a "7" degree rating (dominant) indicates the person has superior qualifications in that trait.

It therefore becomes a simple procedure to determine to what degree the person matches the standard of nurses. The Q/R is administered to her and the resultant profile is compared with that of the job standard. If the nurse's profile falls within the shaded area of the job standard, then her qualifications meet the requirements of the position. A deviation in any area is a danger signal, indicating that she has qualifications either too high or

*Conducted by the Bureau of Personnel Research, Tarzana, Calif.

The author is director of the Bureau of Personnel Research, Tarzana, Calif.



Profile of an ideal nurse based on composite study of 117 superior nurses. Figures 0 to 7 show range of capabilities and limitations. A "0" rating shows that person tested has no qualifications in the indicated trait, while a "7" shows superior qualifications. Candidate's score is matched against a job standard (shaded area).

too low in that particular trait, a possible deterrent to success.

It must be recognized that even though all the nurses have had about the same training, have been graduated from accredited nursing schools, passed similar state examinations, and so on, still they remain individuals, with differences in personality and outlook which make for success or failure in different phases of nursing.

Consequently, although it is ideal that the nurse's profile fall within the shaded area in all respects, discretionary power rests with the hospital management. If a nurse vacancy must be filled and there is no completely qualified candidate for the position, the hospital administrator may relax his selection standards in some regard. Nevertheless, if he uses the Q/R technic, he will know what to expect of the nurse and, with the cooperation of the director of nurses, can use careful assignment methods and perhaps additional training where it is needed in order to make the most of her knowledge and skills.

The job standard based on the nurses in this study proved to be illuminating. It will be observed that the range of qualifications is most dominant in five major areas: physiology, foods, instruction, public contacts, and consulting. These, of course, reflect the very nature of the job.

In terms of physiology, it was not surprising to find that 97.5 per cent of the nurses expressed an enjoyment in studying about the human body. (What made the other 2.5 per cent decide to take up nursing?) Some 80 per cent obtained a first-aid certificate, and 89.3 per cent want to make medical science their life work. All of the nurses held an R.N. license, indicating graduation from an approved school of nursing and passing of the state examination. Among the training courses taken by this group, anatomy and hygiene were the commonest, followed by bacteriology and pharmacology.

Along with this interest in the human body, 59.1 per cent showed an interest in dealing with animal life. Very few preferred the study of animal life to the study of human life, but 81 per cent have raised and cared for dogs, cats, fish, birds or other pets.

Because an understanding of the effect of specific foods and food elements on the human system is

an important part of nursing, it was natural to find a high degree of qualification in the foods area. Some 82 per cent of the nurses revealed that they enjoy preparing meals for others and frequently try new food recipes. Little interest was shown in home economics as a life work, however, although 88 per cent showed evidence of training in such subjects as cooking, dietetics, menu planning, and nutrition. The nurse is interested in education and should be qualified to play a leading role in the education and rehabilitation of such patients as may require this attention.

Inasmuch as teaching can be an important part of the job, it was noteworthy that a high degree of qualification was recorded in the field of instruction. Some 88 per cent of the head nurses said they enjoy instructing or teaching people; 56 per cent have had experience in addressing groups, and 55.7 per cent want a life work which includes teaching or supervision. A knack for explaining things to several people at one time (characteristic of the really good instructor) was indicated by 68 per cent.

In the field of public contacts, too, the study showed that the nurses measure up to the requirements of their profession. Generally included among the duties of the nurse are the following: staying in personal touch with each patient; discussing the condition of the patient with family or friends; maintaining a pleasant, helpful attitude with visitors and with other hospital personnel, and cooperating with the head nurse in seeing that the practices and policies of the hospital are complied with.

In connection with these activities, the study showed that 84.1 per cent of the nurses enjoy work which entails giving information or service to the public, while 72.3 per cent reveal a talent for anticipating and satisfying impatient or irritable people.

Results in the consulting area proved to be significant. Here, 92 per cent of the nurses indicate that they like to assist people with their personal problems, and 69 per cent want a life work dealing with such problems. Some 87 per cent give evidence of a capacity to adjust immediately to circumstances as they arise – a necessary characteristic of the successful consultant in almost any field.

(*Continued on Page* 128)

Job Standard for HEAD NURSE

Profile

ELEMENTS								
ARTS								
1. Music	0	1	2	3	4	5	6	7
2. Art	0	1	2	3	4	5	6	7
3. Dramatics	0	1	2	3	4	5	6	7
4. Dancing	0	1	2	3	4	5	6	7
5. Graphic Arts	0	1	2	3	4	5	6	7
6. Crafts	0	1	2	3	4	5	6	7
BIOLOGY								
7. Physiology	0	1	2	3	4	5	6	7
8. Zoology	0	1	2	3	4	5	6	7
9. Botany	0	1	2	3	4	5	6	7
10. Foods	0	1	2	3	4	5	6	7
11. Sports	0	1	2	3	4	5	6	7
COMPUTATION								
12. Accounting	0	1	2	3	4	5	6	7
13. Mathematics	0	1	2	3	4	5	6	7
14. Drafting	0	1	2	3	4	5	6	7
15. Purchasing	0	1	2	3	4	5	6	7
16. Records	0	1	2	3	4	5	6	7
17. Dexterity	0	1	2	3	4	5	6	7
LITERARY								
18. Journalism	0	1	2	3	4	5	6	7
19. Language	0	1	2	3	4	5	6	7
20. Transcription	0	1	2	3	4	5	6	7
21. Advertising	0	1	2	3	4	5	6	7
22. Research	0	1	2	3	4	5	6	7
PHYSICAL								
23. Tools	0	1	2	3	4	5	6	7
24. Machinery	0	1	2	3	4	5	6	7
25. Transportation	0	1	2	3	4	5	6	7
26. Strength	0	1	2	3	4	5	6	7
27. Hazards	0	1	2	3	4	5	6	7
SOCIAL								
28. Management	0	1	2	3	4	5	6	7
29. Instruction	0	1	2	3	4	5	6	7
30. Public Contacts	0	1	2	3	4	5	6	7
31. Sales	0	1	2	3	4	5	6	7
32. Consulting	0	1	2	3	4	5	6	7
33. Religion	0	1	2	3	4	5	6	7
34. Services	0	1	2	3	4	5	6	7
35. Investigation	0	1	2	3	4	5	6	7
36. Discipline	0	1	2	3	4	5	6	7
TECHNOLOGY								
37. Chemistry	0	1	2	3	4	5	6	7
38. Astronomy	0	1	2	3	4	5	6	7
39. Electricity	0	1	2	3	4	5	6	7
40. Mechanics	0	1	2	3	4	5	6	7
41. Construction	0	1	2	3	4	5	6	7
42. Geology	0	1	2	3	4	5	6	7
43. Physics	0	1	2	3	4	5	6	7
44. Aeronautics	0	1	2	3	4	5	6	7
45. Standards	0	1	2	3	4	5	6	7

Job standard for a head nurse. This is a transparent plastic grid with shaded areas showing the skills and knowledge essential for success, based on composite study of superior personnel in this category. If a nurse's profile falls within the shaded area of the job standard, her qualifications meet requirements of the position.

Careful study of procedures and work flow made it possible to convert a surgical suite of two large operating rooms into a three-room suite plus ancillary facilities and recovery room

Three Operating Rooms Grew Out of Two

WHEN the idea of a functional study of a major operating room first presented itself to us the objective was nothing more than to determine with some degree of accuracy the optimum size of such a room — a matter about which there was then a considerable difference of opinion.

Little did we realize what this would lead to. The end result was a study which took five years and was published in a series of 12 articles in 1953. Nor was that really the end. Strangely enough the "optimum size" objective never materialized as such. The problem turned out to be far more complex. Among other things it was learned that successful operating suites would always be the result of careful tailoring to fit the specific needs of each respective hospital, taking into consideration also such new technics as may develop from time to time.

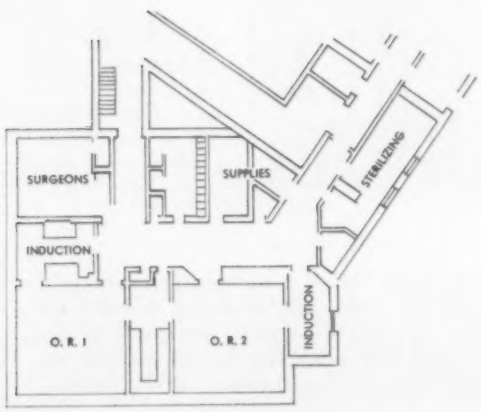
Mr. Markus is a partner in the firm of Markus & Nocka, architects and engineers, Boston.

The operating room size was only one of many important aspects. The data developed turned out to be extremely useful in every stage of planning. In particular it gave us a better grasp of operating suites as a whole in which the plan was based specifically on the basis of control, function and flow, rather than the usual series of rooms which are, then, appropriately labeled. So far, no two of our operating suites have presented an exact duplicate in requirements and of equal interest is the fact that there is not a single rectangular operating room among them which could be delineated on the basis of two dimensions.

As studies developed it was felt that the mere saving of space should never be the main objective. If such savings did materialize, well and good, but the prime consideration was for the highest possible degree of efficiency in surgery. However, in the situation presented by the Free Hospital for Women, Boston, for the first time we were faced with a problem that hinged on space economy and our data were put to a new test. In brief, the problem was this:

The Free Hospital for Women is devoted entirely to gynecology and as such is a well recognized research and teaching center. Its plan is to remain primarily a teaching center without increasing its bed capacity. Nevertheless, its research programs are constantly expanding and it did need increased and better surgical facilities.

The surgical suite had two large operating rooms and not much else. It



Existing Plan (as it was)

Scheme A

View from nurses' station. Right and left are partial views of the three operating rooms. Instrument storage and processing are in the center.

Frederick E. Markus

was located in a one-story and basement wing. There was need for a third operating room. Lacking also were a recovery room, a nurses' lounge, anesthesia workroom, supply room, and a more adequate nurses' station.

A mere addition to this wing appeared to give no realistic solution to this problem. It was also evident that the requirements for this type of surgery are quite different from those of the average general hospital. With their surgery confined to a specialty, the entire surgical staff had developed a high degree of efficiency with respect to the peculiar requirements of gynecology. For example, before surgery begins, every patient is given a routine internal examination to search for any trace of cancer. After this the operating table with patient is reversed. This routine has been established to give the best visibility for seated observers.

All facilities as a whole could be designed more specifically than where many types of surgical procedure must be accommodated. The first step, therefore, was an intimate study of function as it related to every aspect of this specialty. Ten days were devoted to observation and recording from which flow studies and work place layouts were made. For example, many assembly operations which were found to require much walking to various storage or pickup points or work areas were combined to produce a one-station, efficient right and left hand work place layout. Observation and recording of work flow was then supplemented by discussion and conferences with staff members.

Next an abstract design was made of each element required in the suite of which the operating room was in itself a composite item. These represented, first, single units of equipment, such as operating tables, instrument tables, and so on. Next, templates were made of groups of equipment in their use position, as for example, three or four instrument tables for group loading or group parking; or work counters, shelf storage and standup writing desk as a work center. Next came equipment and the operating personnel as a group, *i.e.*, the space and shape of the surgical team in action and the same for the space and shape for the various types of induction procedures.

When these elements were found to be satisfactory and converted into units of space, much to our surprise their combined area did not exceed

Scheme B

The existing operating suite (far left) was anything but functional. Heavy center supporting walls, large air ducts, and awkward room shapes entirely unrelated to function all conspired to produce a deficiency of necessary facilities, with resulting lack of efficiency. Scheme A (center), although it exceeded all expectations, nevertheless lacked Dr. Carl Walter's concept of positive traffic control because of the location of the surgeons lounge and locker room. Surgeons in street clothes would have had to go through a restricted area to reach them. In Scheme B (left), which is now in use, all traffic is through the right-hand entrance and is readily controlled. This scheme appears to meet all the requirements for efficient gynecological surgery. Although anesthesia inductions are now performed in surgery, space is provided for waiting patients, which is most convenient.

THE PLAN SELECTED PROVIDES FOR CONTROL OF TRAFFIC IN THE AREA

the gross space available in the existing wing. We knew then that at least in theory a new suite meeting all requirements was within the realm of possibility without any enlargement of the wing. This is further explained by the fact that the original plan was wasteful of space for a number of reasons: lack of functional planning, excessively thick internal bearing walls, large and obsolete duct shafts, and much excess space where it served no purpose.

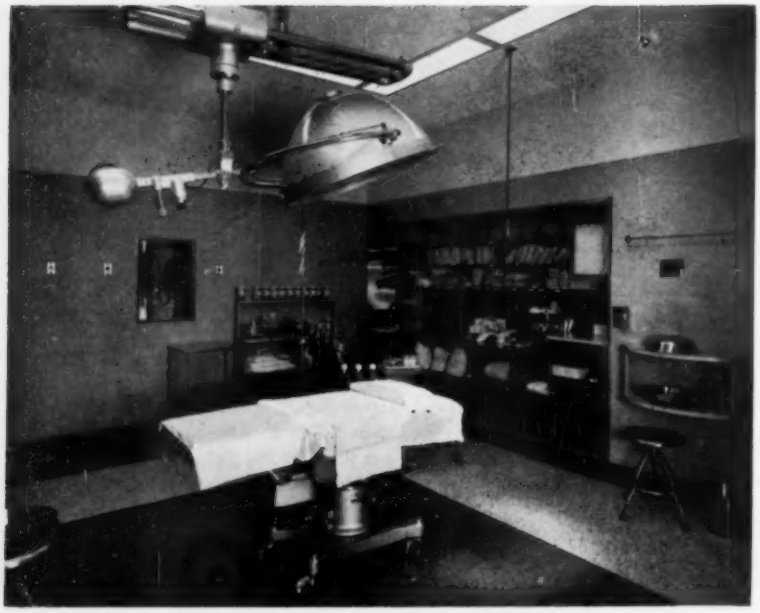
The decision therefore was to try for a solution by a complete stripping of the interior, substituting beams and pipe columns for interior brick-bearing walls, and replanning the whole department. Ultimately, there were two approximately comparable solutions from which to choose, either of which appeared to meet all requirements.

As a final check, the studies were mounted on a wall near the nurses' station and an observer spent another week following every move of the personnel and noting its counterpart on the new scheme of things. In case of doubt about some particular procedure, the staff was right on hand for clarification, and inasmuch as all members had participated in this problem from the very beginning they were familiar with every development.

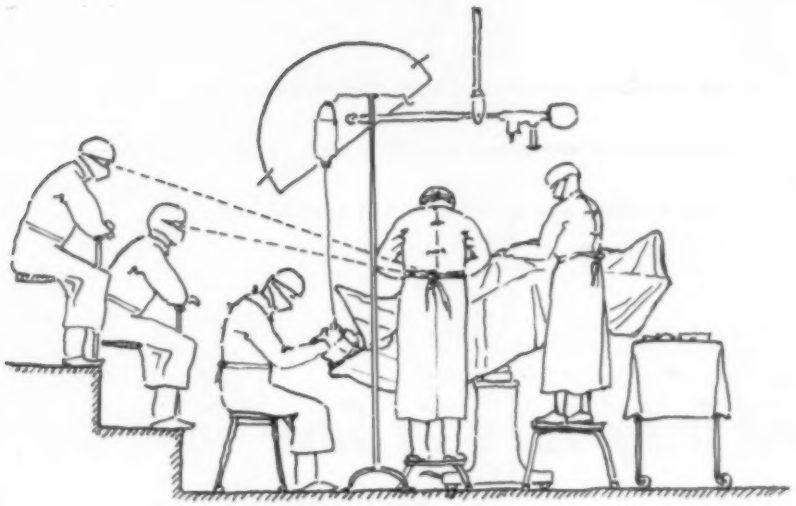
At first, scheme "A" was felt to be the better choice. However, in scheme "A" the surgeons could reach their lounge and locker room only by passing through the restricted area or entering via the emergency exit, thereby complicating control. In scheme "B" all traffic is via the door nearest the surgeons' lounge and the opposite door is merely an emergency egress. This scheme was finally chosen.

The actual status of the three induction areas or alcoves adjacent to the operating rooms has changed since completion of the suite. These areas were originally requested specifically as induction rooms and their equipping was carefully worked out with the anesthetist. However, when the construction was finished a change was made in the anesthesia staff and under this new setup these rooms were no longer used for induction. Nevertheless, they were also intended to serve for patient parking and this has been found extremely convenient. The patients can now be brought early to surgery to avoid loss of staff time. This alcove provides a specific place to leave the patient with reasonable privacy. The patient can be easily checked for adequacy of preparations if need be. Finally, if there should be a change in policy in anesthesia or if an unusually heavy schedule demands more intense operating room use no physical adjustment need be made should it again be decided to use the rooms for induction as before.

Left: Traffic in recovery room is one-way toward the door shown. Lighting is totally indirect for patient comfort.



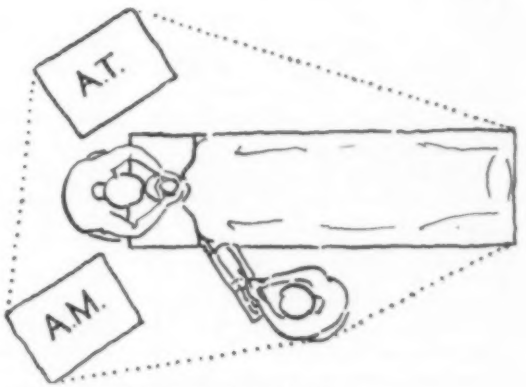
Nurses' corner of one of the three identical operating rooms. Sterile operating field and parking strip are established by darker floor.



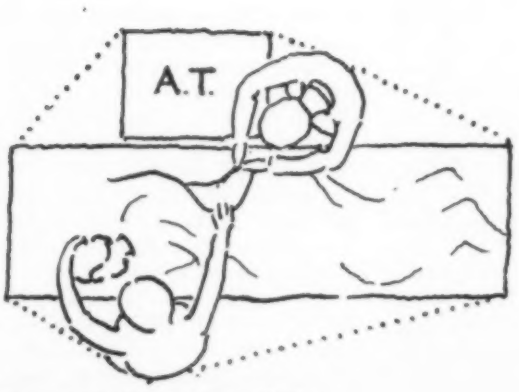
Teaching is an important factor. To afford the greatest visibility to observers, the patient is examined internally, then reversed into deep Trendelenburg position.

Sketches Show Space Requirements for Anesthesia in Free Hospital O.R.

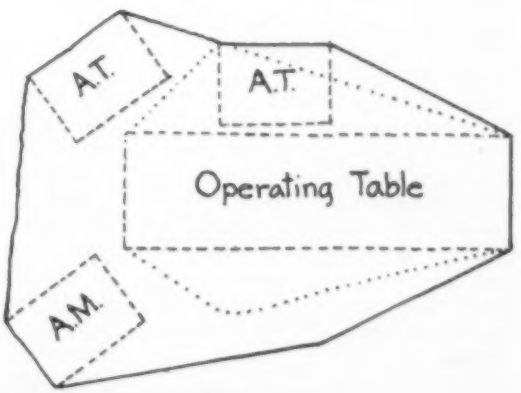
All spaces were established by actual measurement during work. Where related work was scattered, new work elements were created synthetically. This also helped to establish the optimum. For example, suture jars, needle boats, and transfer forceps were stored at the point where instrument tables were prepared. The illustrations here show the step-by-step buildup of the net space required for the induction of anesthesia including space for the anesthetic machine (A.M.) and table (A.T.). To this is added a strip of space for circulation, again based on the observed traffic pattern. ■



Space required for general anesthetic.



Space required for spinal anesthetic.



Composite space requirement.

By replacing messengers with pneumatic carriers this hospital has reduced corridor traffic and conversation and gained hours of working time

They Send It by Tube To Save Time and Traffic

Gordon W. Gilbert

PNEUMATIC tube carriers save employes' time and improve efficiency of message delivery, we found at Huntington Memorial Hospital, Pasadena, Calif., after the system was installed as part of a modernization and reconstruction program.

After studying the use of such systems in other hospitals, we decided to exploit the pneumatic tubes for as many uses as possible. Why not use them to speed charge slips to the accounting department, or last-minute diet changes to the kitchen? Why not relieve nurses and aides of as much messenger work as possible, leaving them free to do their real job?

This idea began to take firm root as we reexamined our own administrative practices. Throughout the day, innumerable trips down the corridors were being made by aides and ward clerks to carry slips of paper or small articles here and there.

An inside messenger service, of course, can take care of routine deliveries, but it is our experience that it will never curb human impatience for high-priced people usually hate to wait. Quite commonly, indeed, they will trot along with the messenger – and here we have two people wasting their time running an errand that should be turned over to a mechanical system.

Mr. Gilbert is administrator of Huntington Memorial Hospital, Pasadena, Calif.

From central supply to our new maternity building, and return, is a block-and-a-half walk, plus two elevator trips. Even without allowance for one or two brief conversations with friends met en route, the round trip is likely to take 10 minutes or more.

On the other hand, a pneumatic carrier propelled at 25 feet per second could certainly cut this figure drastically. Without actually clocking elapsed time, we could see that the amount of effort spent each day on miscellaneous errands by employes of all grades must mount to impressive figures.

System Electronically Operated

The system designed for our hospital consists of 20 stations strategically distributed over three-fourths of a city block, including the five floors of the main building and portions of three other buildings. The small cash carriers familiar in many department stores for making change have been supplemented by larger models capable of holding objects as large as a medium-size x-ray film or a package of surgical instruments. Higher powered airstreams propel these carriers rapidly under guidance of electronic controls that operate like a modern railroad switchyard in automatically dispatching many incoming and outgoing carriers over a single pair of "tracks."

The carriers are automatically directed, *i.e.* they are "addressed" to the desired destination by setting an indicating dial on the carrier itself. As the traffic stream passes through key points, an electrical sensing unit reads the address and deflects the carrier into the proper branch tube leading toward its destination.

The employe dispatches a message or package by simply inserting it into the carrier, which is closed with a snap fastener, and setting two rotating rings to the code number of the station addressed. Our code numbers range from B-1 for the x-ray department to C-4 for the clinical laboratory. Inserting the carrier into the outgoing tube instantly starts it on its way.

Central supply has repacked many items into a long, round shape to fit the carriers, so that we are able to send all sorts of small items formerly carried by hand through the halls. We also move most of our professional paperwork by tube, *i.e.* charts, requisitions and so on. Prescriptions are sent to the pharmacy and nonliquids are returned via carrier. We do not send urine specimens or other liquids, but glassware, where well padded (*e.g.* sterile syringes), travels by tube.

Our administrative paperwork also moves mainly by tube – maintenance work requests, payroll information, personnel reports, and charge slips. Confidential material is sent in sealed

A pharmacy employe prepares to send prescription through the tube carrier. Pharmacy is one of the greatest users of system.

envelopes. We do not send money because tubes are not placed under one individual's control, hence responsibility cannot be pinpointed.

Many minor chores are minimized by use of the tubes such as the relaying of telephone messages for patients, and delivering patients' mail. In short, all 26 major departments transmit all possible items for every purpose.

After the tube system had been in operation about six weeks, I asked a pharmacist how it seemed to be working.

"Very well, I suppose," he said, "but I must say we all miss seeing our friends."

It was true. My own first impression of the main corridor leading to the pharmacy was that never in my life had I seen so many people going to — or returning from. I assumed all the errands were important, but the throng at the pharmacy around 10 o'clock on Monday mornings often suggested a department store's bargain basement on sale day.

It is only natural that around coffee time nurses may have prescriptions to fill, and if they, while waiting, should happen to be asked by a young doctor or resident to join him for coffee, they can hardly refuse. It also is natural that a messenger sent on a trip from central supply to the personnel department, up five floors and down half a block of corridors, should pause en route to visit with a friend. That also is human. But once tube transportation took over, it was interesting how soon this heavy traffic in our halls became a thing of the past.

Simultaneously other changes began to appear, particularly in workloads. The ward clerks at nurses' stations quickly felt the effect. Previously they were very busy between 8:30 and 10 a.m. taking diet change orders, requests for laboratory tests and x-rays, and getting prescriptions filled. With the advent of the carriers all these requisitions were sent through the tubes in a matter of minutes, leaving an unbelievable amount of time free for the ward clerks to perform other duties.

As attending physicians made their rounds and diet changes and new prescriptions were shuttled off to kitchen and laboratory, requests for blood counts and pictures were arriving sooner, clearing up rush-hour congestion in these departments. From about 3 p.m. on the results of these tests and x-ray examinations arrived back on the floors. Instead of paying technicians to walk around as inside messengers and place the reports on the charts, we use gum stock for the report forms so the technicians remain in their respective departments and the ward clerks attach these findings to the patients' charts.

We found that accounting material now was trickling steadily into the business office throughout the day, instead of arriving suddenly in a last-minute deluge. Thus we speeded up posting of accounts, as well as clearing of personnel records for new employes. Prompt billing of charge slips sharply reduced the chance that some items might not be posted before patient's checkout.

Incidentally, one mechanical bookkeeper last year posted just under 500,000 charge tickets, a feat made possible, in part, by the earlier delivery by tube.

Changed Requests Method

Tube transmission of requisitions has eliminated unwritten telephonic communications that leave no record. For instance, we have changed our method of making out maintenance work requests. The originating department now retains one copy and sends two to the maintenance department. The chief engineer keeps one copy and gives the other to the workman assigned to the job. When he has finished, he returns the slip to his chief. There are no untraceable telephone messages to get lost.

We discovered that in planning remodeling and building operations, we could regroup functions with a freer hand because rapidity of the tube system made travel distance less important. We decided, for instance, to put

central supply in a more isolated location. Since requests usually would be made by tube and filled the same way, there would be relatively few occasions for one to go to the department.

At the outset we kept the tube system operating 24 hours a day, but this proved unnecessary. By watching the monitor — the "switchyard" where passing carriers are electronically shunted to their destinations — we saw that for practical purposes the system could be closed down between 9:30 p.m. and 7 a.m.

Tips on Using Tube System

To other hospital administrators who may be planning installation of pneumatic systems, we offer the following observations based on our own experience:

1. Publish tube station numbers in your local organizational directory alongside the corresponding telephone numbers. Thus they are easily found and thought of in terms of geography.

2. Designate persons in each department to be responsible for control of the carriers, so someone is always on duty. Usually we designate the ward clerk and head nurse.

3. Mark each carrier with its home station and an individual carrier number so all can be accounted for. Order enough carriers to take care of traffic peaks, since busy stations at rush hours may be inclined to delay return of containers to home stations. The number needed at each station will, of course, depend on the traffic at the particular location, but ordinarily the focal point of greatest activity is the pharmacy.

4. When building, remodeling or installing a new system, allow plenty of room for access to the switching stations, leaving service points accessible — the same precaution as with plumbing fixtures.

5. Train each new employe so he will have a clear mental picture of how the system works. Using the tubes is simplicity itself; all the employe has to remember is to (a) close the carrier by fastening the snaps, and (b) insert it into the tube right side up. Proper orientation of new personnel thus reduces the human problems. Actually, we have not had a single mechanical failure and the occasional interruption invariably has been caused by human frailties. When this happened the avalanche of indignant telephone calls demanding to know how soon service would be restored gave eloquent testimony to the reliance that was being placed upon the system.

6. We find a preventive maintenance program as valuable here as in any other phase of management. We recommend designating one man to be responsible for periodic inspection. He should have an understudy to cover sickness and holiday absences. We picked a man with some electrical knowledge. By working with a representative of the manufacturer during installation he became thoroughly acquainted with the system. He in turn trained other members of the maintenance department, so all have a rudimentary knowledge of trouble shooting, which is relatively simple. Our preventive maintenance seems to require about 30 man-hours per month, but we feel this time is well spent.

It is difficult to estimate the savings made by use of our pneumatic tube system in terms of time and money. Immediate, demonstrable savings in manpower at this point are minimal (it is a well known fact to administrators that no department can ever get along with less help than it now has!). We do know, however, that we are now getting eight hours' worth of service per day from each nurse, where previously we had been getting about six hours of nursing plus two hours of errand running. In surgery and maternity departments, where the highest premium is placed on time, we know emergency supplies and other high priority items are moved much faster.

The system may have disrupted the hospital's social life to some extent, but while this was missed at first, it is no longer mourned. The convenience of disposing of petty chores by stuffing them into the tube has become well recognized. Self-preservation, the instinct to save one's feet, guarantees that employes will use it. It is much more satisfactory to dispatch a carrier and forget it than to put an order on the spindle and wait impatiently for a messenger to pick it up.

There also is a safety factor in times of emergency. Written requests often eliminate the danger of serious misunderstanding.

Over-all, we can see we are getting greater efficiency in the use of personnel and in the long run will be able to do more and better work with the same number of people. We also know we are giving better care. ■

View of nurses station which uses carrier for materials and requests. Previously the ward clerk spent much of her time as a messenger.

ABOUT PEOPLE

Administrators

Ralph M. Hueston, superintendent of Chicago Wesley Memorial Hospital, Chicago, since 1947, has retired. **Kenath Hartman,** assistant superintendent, has been named to succeed him. Mr. Hartman holds a master's degree in hospital administration from Northwestern, where he is presently a lecturer and coordinator of the program in hospital administration. Mr. Hueston started his career as hospital

Ralph M. Hueston

Kenath Hartman

superintendent in 1924 at Galesburg Cottage Hospital, Galesburg, Ill., where he served two years. For nine years he was head of Silver Cross Hospital, Joliet, Ill., and served Hurley Hospital, Flint, Mich., for 11 years before going to Wesley. He served as president of the National Association of Hospitals and Homes of the Methodist Church, president of the Chicago Hospital Council, and a member of the board of directors of Community Hospital, Evanston, Ill., Chicago Hospital Council, Illinois Hospital Association, Hospital Service Corporation, Cook County Hospital School of Nursing, Illinois League for Nursing, and Northwestern University.

Daniel H. Schwartz has been appointed assistant director of Montefiore Hospital, New York. Previously he had been assistant to the executive director of National Jewish Hospital, Denver. Prior to that he was national deputy director of public education for the American Cancer Society. He is a graduate of Dartmouth College and has a doctor of philosophy degree from the University of London.

Walter L. Huber has been appointed administrator of Tacoma General Hospital, Tacoma, Wash., succeeding **A. L. Babbit,** who resigned but will continue to assist the hospital with a current construction project. Mr. Huber has been with the hospital for nearly 10 years. He had served as business manager for five years when he was appointed assistant administrator in 1955.

James Russell Clark, for the last 13 years director of Brooklyn Hospital, Brooklyn, N.Y., has resigned. Previously he had been director of the Washington service bureau of the American Hospital Association and at one time served as director of Southside Hospital, Bay Shore, N.Y.

Paul W. Askue has been named administrator of Gnaden Huetten Memorial Hospital, Lehighton, Pa. He had been administrator of Twin City Hospital, Dennison, Ohio. Mr. Askue is a graduate of Western Reserve University and of the course in hospital administration at Northwestern University.

Dr. George W. Dana has resigned as administrator of North Shore Hospital, Manhasset, N.Y., to become executive director of the South Western Medical Foundation, Dallas.

Lt. Lionel G. Price, MSC, formerly administrative assistant at Methodist Hospital, Indianapolis, is now administrative director of outpatient services at Fairchild Air Force Hospital, Fairchild, Wash. He is a graduate of the Northwestern University Program in Hospital Administration.

Gibson Howell, administrator of Louise Obici Memorial Hospital, Suffolk, Va., has been appointed administrator of Norfolk General Hospital, Norfolk, Va. He will join the staff at Norfolk about May 1 for a training period and will assume his duties September 1. **Walter L. Beale,** present administrator of the Norfolk hospital, is resigning to return to hospital consultation. Mr. Howell has been administrator at Louise Obici since 1951. He was formerly administrator of Raiford Memorial Hospital, Franklin, Va., and director of the school of hospital administration at Medical College of Virginia.

Frank Scott has succeeded **William Rich** as administrator of Lincoln Hospital, Durham, N.C. Mr. Rich retired after 25 years as head of the hospital.

Sister M. Pretiosa has been appointed administrator of Mount Carmel Hospital, Colville, Wash., succeeding **Sister M. Igmara,** who has been transferred to St. Martin's Hospital, Tonasket, Wash., as administrator.

H. Eliazarian has been appointed assistant administrator of Nyack Hospital, Nyack, N.Y. He is a graduate of the course in hospital administration at Northwestern University.

Corliss Morris has been appointed administrator of Hancock County Memorial Hospital, Greenfield, Ind. He was previously administrator of Highlands Community Hospital, Hillsboro, Ohio. Mr. Morris succeeds **Harold B. Burr,** who had been administrator for three years. The new administrator was formerly assistant administrator for six years at Bethesda Hospital, Cincinnati. He was previously administrative assistant for six and a half years at Lima Memorial Hospital, Lima, Ohio. Mr. Morris has attended Toledo University, University of Cincinnati, and Xavier University.

Harold E. Springer has been appointed business manager at Peoria State Hospital, Peoria, Ill. He was formerly administrator at Memorial Community Hospital, Edgerton, Wis. Mr. Springer is a graduate of the Northwestern University Program in Hospital Administration.

Harold Springer

Harold R. Funk has been appointed executive director of Akron City Hospital, Akron, Ohio. He has been with the hospital since 1946, serving as assistant director since 1953 and acting executive director since April 1959. Mr. Funk is a member of the American College of Hospital Administrators. He succeeds **Worth L. Howard,** whose death is reported on page 156.

Walter Diggs has been appointed administrative assistant in the outpatient department of Johns Hopkins Hospital, Baltimore. He is a graduate in hospital administration from the University of Minnesota. The hospital also announced the appointment of **Conrad G. Maygers** as assistant controller.

(*Continued on Page* 150)

Medical Research Raises the Quality of Care

Any hospital can plan a medical research program to fit its needs and budget, says the author, who points out that such a program attracts the kind of staff men whose zest for progress will be of benefit to patients

Sheldon S. King

THE medical research program of Mount Sinai Hospital in New York has produced many highly significant discoveries. These include such classic publications as the first description of Brill's disease and such technics as the use of endotracheal anesthesia in thoracic surgery (Lilienthal). The hospital is understandably proud of these and all of the other accomplishments of its research workers.

The projects conducted by our staff members, the majority of whom are concurrently engaged in the private practice of medicine, represent all of the clinical and laboratory disciplines. The budgets of the projects range from $100 to thousands of dollars.

Some of these investigations have provided opportunities for the attending staff to expand its stock of therapeutic tools by controlled use of experimental drugs. Other (nonlaboratory) investigations, known as clinical registrations, stimulate methodical observations of patients with selected diagnoses. As a result of these studies, the time interval between medical discoveries and their use in patient care has been reduced.

Any interested hospital can plan a research program commensurate with its ambitions and facilities. Equipment normally used for routine patient care (*e.g.* laboratory facilities) can be

(*Continued on Page* 90)

Mr. King is coordinator of patient services, Mount Sinai Hospital, New York. This article is condensed from an unpublished master's thesis, Yale University.

How and Where To Find Funds for Research Program

Permanent research funds. The hospital research policy should be formulated by the board of trustees, and translated by the administrator into working mechanisms. Among the fundamental requirements is the need for permanent research funds, since research activities should not be financed out of the hospital's operating budgetary funds. Most extramural fund sources do not provide sufficient monies to cover all of the costs of equipment and material needed for research projects. The hospital must be prepared to contribute funds for the support of grant sponsored research, as well as for trial periods in research projects. Although these intramural funds may make up only a small fraction of the total research budgets, hospital general and special research funds are of great value as a stabilizing, perpetuating influence. Sources of such permanent funds in the local community include staff physicians, trustees, former patients, affluent citizens, and local industry.

Application design. The design of an application form will help determine the success of research workers in obtaining outside financial support. It should be accompanied by a set of clear, concise instructions to avoid ambiguities in the preparation of the application. The title of the project, research workers involved, space and facilities required, personnel needs, budgeted expenses and expected sources of funds and a detailed project design, all accompanied by the requisite approvals, should be contained in the completed application. It should answer all possible questions to which it might be subjected by a research committee.

Research corporation. The formation of a research corporation which could receive research funds would be a useful adjunct to the program. Titles to tests and procedures and patents on inventions and discoveries could be vested in the corporation, with royalties from licensing and use of research products accruing to the permanent research funds. Creation of a research corporation would help identify the research function as a separate hospital element and would improve both the care of patients and medical education activities. ■

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utilized in establishing the program with a few small projects. The practical results that may be obtained, although valuable as concrete accomplishments, would not be as important as the vitalization of the staff's scientific thinking and its increased morale and pride in professional accomplishment.

A hospital with a research program in which interns and residents may participate is more attractive to prospective house staff members. Along with the development of the hospital's practicing staff, the community is then assured of a continuing body of medical leaders. Regardless of tangible, readily employed results, a research program in the hospital produces a higher level of medical care for the community.

Developing the Program

In the initial stages of developing a research program, the administrator must ascertain that the hospital's medical staff is ready to conduct experimental activities. Impetus for research, ideally, should come from the professional staff. Most physicians are eager to engage in scientific investigations and are cognizant of the benefits that would accrue to themselves and to their hospital. It is the task of the administrator to learn for himself the values of research for his institution (regardless of its size) and to obtain the interested support of the hospital's governing board.

Facilities. A survey of available facilities, including laboratory equipment, personnel and space, must be undertaken to determine the scope of research projects which could operate in the hospital environment. The advice of the chief of the laboratories and members of the medical board should be sought in this evaluation. If no experienced researchmen are members of the professional staff, the guidance of experts in the medical community or in near-by hospitals conducting research programs should be obtained.

Professional staff. To lend professional direction to a general research program, a director of research might be appointed by the board. The chiefs of the services in the hospital should assume responsibility for advisory and supervisory functions for projects conducted by members of their staffs. Provision should be made to allow special privileges for talented researchers who are not on the staff. If it is within the intended scope of research operations, the appointment of full-time research physicians would lend continuity to the program, retain high investigative standards, and assist in the development of other researchers. However, inasmuch as most of the work will be performed by staff physicians in private practice who would devote part of their time to research, the absence of a permanent, full-time research corps need not handicap the small hospital's program.

Research committee. The formation of a research committee to evaluate each project application is essential. This could be a joint committee of representatives of the board of trustees, administration and the medical staff or membership might be limited to the administration and physicians. In either plan, the actions of the committee should be presented as recommendations to the board of trustees for its approval. The research committee should consider each application on its individual merits and in relation to the facilities and program of the hospital. Examination of the credentials of nonstaff physicians who wish to participate in the hospital's program should be one of the research committee's functions.

Administrative Function

Programing the project. Project applications should be submitted for evaluation and action. Copies of the application and meeting agenda should be distributed to each member of the committee at least one week before the scheduled meeting. An appraisal of the ideas and technics described, facility and staff estimates, and project schedules is part of the committee's responsibility for project selection. The recommendations of the committee should then be passed to the governing board for approval. After approval by the board, the research applicant may apply to donor sources for grant support. Funds are received and accepted by the hospital for the conduct of the specific project.

Communications. Implementation of an approved project should fall to the hospital administrator. An authorization form should be distributed to all departments involved in the research project (personnel, purchasing, accounting) listing the research worker's name, funds required, personnel to be recruited, information identifying the fund account, and the approved research period.

Directing the project. The principal investigator should be responsible for the technical and administrative aspects of the research project. It would be his job to enlist the cooperation of his confreres and to direct other personnel (*e.g.* technicians).

The personnel department should assist the investigator in recruiting authorized research personnel. All purchases should be made through the hospital's purchasing agent, after approval by the accounting section. The accounting department should maintain a record of all research expenses, approving only authorized expenditures per the approved budget.

Controlling the project. Professional and administrative controls are needed to ensure that the project proceeds as planned.

Professional controls should take the form of semiannual progress reports. Since many projects would be limited to a single year's duration, a six-month progress report and a terminal report (same form) at the project year's end would constitute the professional controls. These reports should briefly summarize project operations, and should serve as a means of evaluation. A file of due dates of progress reports for each project should be maintained by the administration. Reminders of report dates should be sent to the principal investigators to assure submission of reports on schedule.

Budgetary controls should consist of monthly and semiannual reports for each project. These should be channelled through the administrator and director of research and examined to ensure that purchases and other expenditures remain within the budget.

Evaluation, reappraisal and publication of results. Measurement of the progress and results of a project should be a part of the research administrative cycle. Reports of progress, terminal reports, and project renewal applications should enable the research committee to evaluate results. Design changes should be recommended for renewal projects, when the appraisal procedure indicates the necessity for such changes. The experience gained in examining project results will enable the research committee to develop sound operating plans. ■

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References: 1. Stone, H. H.: Monographs on Therapy 3:1 (May) 1958. 2. Davies, J.I., and Hansen, J. M.: Clin. Res. Notes 2:5 (May) 1959. 3. Stone, H. H.: Clin. Res. Notes 2:3 (May) 1959.

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International Classification Vs. Standard Nomenclature

By Robert S. Myers, M.D.

A RECENT report[1] demonstrating the superiority of the "International Statistical Classification" over the "Standard Nomenclature of Diseases and Operations" as a coding system for disease indexing in hospitals caused anxiety and resentment among the champions of SNDO. The latter feared that universal adoption of the ISC indexes would cause a deterioration of clinical research because of the simple and unrefined nature of the ISC codes and because it would encourage physicians to abandon the more accurate and specific nomenclature provided by the Standard Nomenclature.

Dr. Robert S. Myers

These allegations are contrary to the experiences of the Professional Activity Study (PAS)[2] which for the last five years has used the ISC for coding disease indexes for more than 2 million patients in the large group of hospitals participating in the PAS.

The PAS agrees with these conclusions of the study made by the American Hospital Association and the American Association of Medical Record Librarians:

1. The coding and posting time is less with ISC than in SNDO. This is not hard to understand when one realizes that SNDO has approximately 16,000 identifiable and specific disease entities, whereas ISC, as expanded by the PAS, has in use approximately 3350 codes. There are, thus, almost five times as many codes in the SNDO as there are in the expanded and practicable ISC code used by the PAS.

2. There is a higher degree of consistency and reliability of coding in ISC than in SNDO. This is demonstrated by the confusion which commonly arises in using SNDO to code such a common condition as "infarction of the myocardium" or "coronary thrombosis." This may be coded in SNDO as: 430-516.7 "infarction of the myocardium due to arteriosclerotic coronary thrombosis" or 41 x-942.7 "coronary thrombosis due to arteriosclerosis" or 430-9 x 7 "infarction of myocardium due to unknown cause." The record could thus wind up under any one of three codes depending upon how the physician stated the diagnosis. Under the PAS modified ISC the record would be filed under a single code, 420.3, regardless of the physician's final diagnosis.

3. ISC provides more records pertinent to clinical research than do the SNDO indexes. The reason for this is that the extreme specificity of SNDO makes it difficult to obtain all the records needed for a valid study of a disease condition. For example, a study of Hodgkin's disease involving the spleen is coded 520-832 in SNDO, and if you

[1]Efficiency in Hospital Indexing of the Coding Systems of the International Statistical Classification and Standard Nomenclature of Diseases and Operations, Journal of the American Association of Medical Record Librarians, Vol 30, No. 3 (June) 1959.

[2]Conducted by the Commission on Professional and Hospital Activities, Ann Arbor, Mich. The Commission is sponsored by the American College of Physicians, the American College of Surgeons, the American Hospital Association, and the Southeastern Michigan Hospital Council.

ask the medical record librarian to pull these charts, she will get for you only those charts in which this definite diagnosis has been made. But everyone knows that the physician may not record as final diagnoses *all* of the various manifestations of a disease.

Thus, a patient with Hodgkin's disease of a lymph node of the neck (553-832) or a patient with Hodgkin's disease of the skin generally (130-832F) may each have Hodgkin's disease involving the spleen which was not recorded as a final diagnosis and, hence, not indexed. Thus, these records will not be presented to the physician, and his study of Hodgkin's disease involving the spleen will be incomplete. On the other hand, in the ISC all Hodgkin's disease is listed under a single number (201) and a request for Hodgkin's disease of the spleen will obtain for the physician *all* cases of Hodgkin's disease, regardless of site. To be sure, this will bring forth some records which are not pertinent to the spleen, but this is a matter for the interested physician to determine from a review of the records.

The PAS has found no deterioration in the accuracy or completeness of diagnostic terms during five years' use of ISC. Nomenclature, as defined by SNDO, is used by the physicians; classification, as determined by the ISC, is done by medical record librarians. This is as it should be, for we should expect people to stick to the field in which they are expert. ■

Retail Price Tags Work Well in Pharmacy

The little tags used in retail stores to price merchandise simplify posting of charges to patients for drugs and supplies

Robert J. Wilkins

THE small merchandise price tags used by retail stores to indicate the price of their wares have been adopted by Immanuel Hospital, Mankato, Minn., to charge patients for supplies used in the hospital. This is being done to ensure that each chargeable item is entered quickly and accurately on the patient's ledger.

All chargeable items are recorded on a master list and an item number and price are assigned to each one. Small merchandise tags containing the item number and a coded price are prepared for each item. The tags are affixed to the supply item in the storeroom before it is issued. Supplies are issued to nursing floors on weekly requisition, and when an item is used for a patient, the tag is removed and pasted on a "supplies" charge slip.

Sticky-back tags are used on most items. There is enough adhesive left for the tag to be affixed to the charge slip. If the tag will not stick, it is stapled or taped to the slip. As many as five tags may be put on a single charge slip. However, the charge slip is taken to the business office daily or upon discharge of patient for posting.

The tag system is also used for intravenous solutions. The charge includes administration set and needle. Special supplies such as orthopedic appliances and bone plates are not tagged. These are described in writing on a charge slip and priced from a separate schedule. Routine supplies for maternity patients are packaged in a plastic bag, and a single tag is used to charge for the package. The business office may check any item number against the master list if a patient wants details on any charge.

Equipment needed for this method includes one tag-marker machine with interchangeable type, sticky-back tags (pressure sensitive), and gummed tags (moisture type).

The results have proved highly satisfactory. Among the benefits are:

1. Greater accuracy and speed in charging items to patients. Charges are not forgotten.

2. Greater accuracy in pricing supplies. One person—the storekeeper—does the pricing.

3. Time is saved at the nursing station in originating the charge, and in the business office in pricing the charge. Nurses appreciate having one less clerical chore.

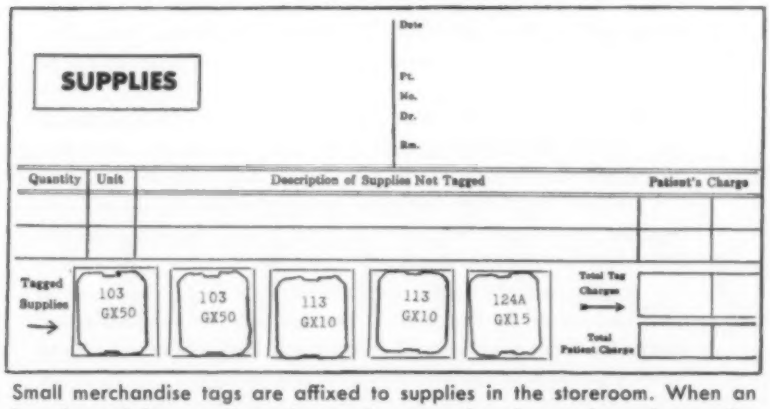
4. More time is required in the storeroom to print tags and mark supplies. However, we believe this is easily offset by the time saved on nursing floors and in the business office.

5. With the master copy in business office, it is easier for personnel to explain questioned charges.

We like it! ■

Mr. Wilkins is administrator, Immanuel Hospital, Mankato, Minn.

Supplies Charge Slip Used at Immanuel Hospital



Small merchandise tags are affixed to supplies in the storeroom. When an item is used for a patient, the tag is removed and pasted on charge slip.

Operating Room Forum

Leave Thermometer at Bedside Where It Can't Spread Infection

By Frances Ginsberg, R.N.

BECAUSE I work with the problems of asepsis and teach operating room nurses and others to play an effective role as advisers and consultants to the rest of the hospital in these technics, I cannot help but comment on dangers in the aseptic technics which I consider a threat to patients, medical or surgical.

Frances Ginsberg

We know that organisms in the nose and throat, particularly the tubercle bacillus, are potentially dangerous, yet the clinical thermometer is often passed among patients with less than effective disinfection in a germicidal solution.

There are, I believe, several methods of solving this potentially dangerous problem.

Undoubtedly the best solution is the individual thermometer technic. With this method each patient is provided with his own thermometer, which is continually stored at his bedside unit in a diluted antiseptic solution, such as alcohol or a quaternary ammonium compound.

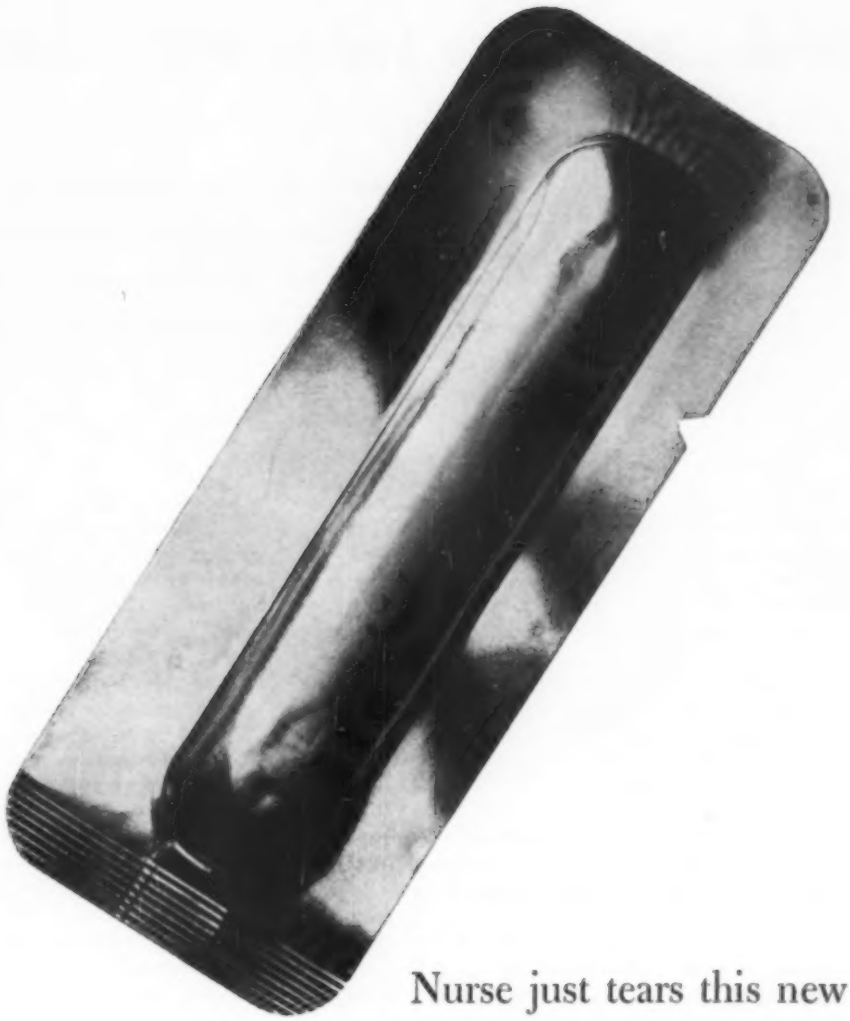
If there are reasons why the individual technic cannot or will not be used, each thermometer should be terminally disinfected after each use; a chemical solution with a broad bactericidal action such as aqueous or tincture of iodine compounds in adequate concentrations should be used. The aqueous solution should be made up of 150 parts per million (ppm), and the tinctures should be cut to from one-half of 1 per cent to 1 per cent tincture of iodine (2 per cent U.S.P.) in dilution with 70 per cent alcohol. This same procedure should be followed for terminal cleaning of thermometers used in an individual technic when the patient is discharged.

A third terminal disinfection technic is that of using synthetic phenolic compounds, in a 1 to 3 per cent concentration. In this method, as in the previous case, the thermometer should first be cleansed with a soap and water pledget, then rinsed in cold water, and then submerged for 10 minutes in the aforementioned solution. It can then be removed, rinsed in cold water, and stored dry in a paper sack or in a covered container.

There are, of course, other problems inherent in this question of using clinical thermometers. One of these is pilferage. If a manufacturer could provide an accurate, inexpensive, disposable thermometer, this problem of pilferage would be solved. Another approach might be to let patients take thermometers home with them, charging them at the same low price the hospital pays.

Bacteria and the various types of infection they cause know no class and are tricky and elusive. Our methods for combating and destroying them must be well ordered and adequate or we will be faced with too little too late for some of our patients. ■

Miss Ginsberg is a consultant on operating room nursing and hospital aseptic technics and a member of the Bingham Associates Program at Boston's New England Center Hospital.



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Search for Better Service Led to Major Saving

An all-out program of reorganization to correct the deficiencies of a decentralized service resulted in better teaching methods, tighter control of food and supplies, reduced staff, and a saving of nearly $100,000

Frank O. Moosberg

REORGANIZATION of a decentralized dietary service has resulted in savings of more than $97,000 at the same time quality and quantity of food were increased at the University of Texas Medical Branch Hospitals, Galveston.

Because of the size of the dietary department — a central kitchen serving 29 floor kitchens — the changeover took the form of a crash program. We reasoned that if emphasis were placed on any one segment of the operation until it was completed, the revised segment might slip back to its original state while other areas were being reorganized. Therefore, all changes had to be in progress at the same time. Coupled with this decision was the fact that only six months remained until the end of the fiscal year. Therefore, the program was geared to a six months' period in order to gain control of food costs.

Two new positions were created: chief therapeutic dietitian and chief administrative dietitian. These two people bore the brunt of the pressures inherent in a rapid departmental reorganization.

One month was used for a survey of existing conditions, and a large number of observations were recorded in order to compile a list of desired approaches. From our experience, this checklist was developed to obtain information on existing conditions in our kitchens:

Equipment.

1. Do ranges and ovens have thermostats? Temperatures of 700 F. will cause the bottoms of ovens to warp from heat. This is the temperature at which ovens do run if not controlled by a thermostat.
2. Are there clocks in kitchen for cooks to check cooking time?
3. Are dippers, spoons, whips and knives available for the cooks?
4. Are range ovens in good working order?
5. Is the peeler overfilled?

Storage Space.

1. Is the diet kitchen refrigerator being used?
2. Are vaults tidy? They will be untidy when everyone has access to them. Is there supervision of the vaults?
3. Is the salad refrigerator used to store vegetables for salad preparation?
4. Are frozen vegetables and fruits stored in the freezers near the vegetable or bakery units?
5. Are there opened cartons of milk in the milk refrigerator?

Issuing of Supplies.

1. Are recipes for controlling quantities used by cooks? Are cooks allowed to draw from the storeroom indiscriminately?
2. Are bread ends saved?
3. Is a definite quantity of dry milk used in products requiring milk?

Time Element.

1. Do cooks go to the storeroom area and wait for all supplies and ingredients?
2. Do cooks walk to the vegetable preparation unit to chop vegetables for seasonings?
3. Do cooks walk around the range island to use the roasting ovens?
4. How much time is consumed by taking cooked foods to the preheating area of the hot carts?
5. What are the ordering schedules for meat, produce and other supplies? Can they be ordered fewer times per week or month? If these supplies are

(*Continued on Page* 100)

Frank O. Moosberg is a dietary consultant with the Iowa Board of Control of State Institutions. At the time this article was written he was director of dietetics at the University of Texas Medical Branch, Galveston. He was previously in the school lunch field. While director of lunchrooms at Brazosport Schools, he was given the Margaret E. Prentice award by the American Food Service Association. Mr. Moosberg has a master's degree in institution administration.

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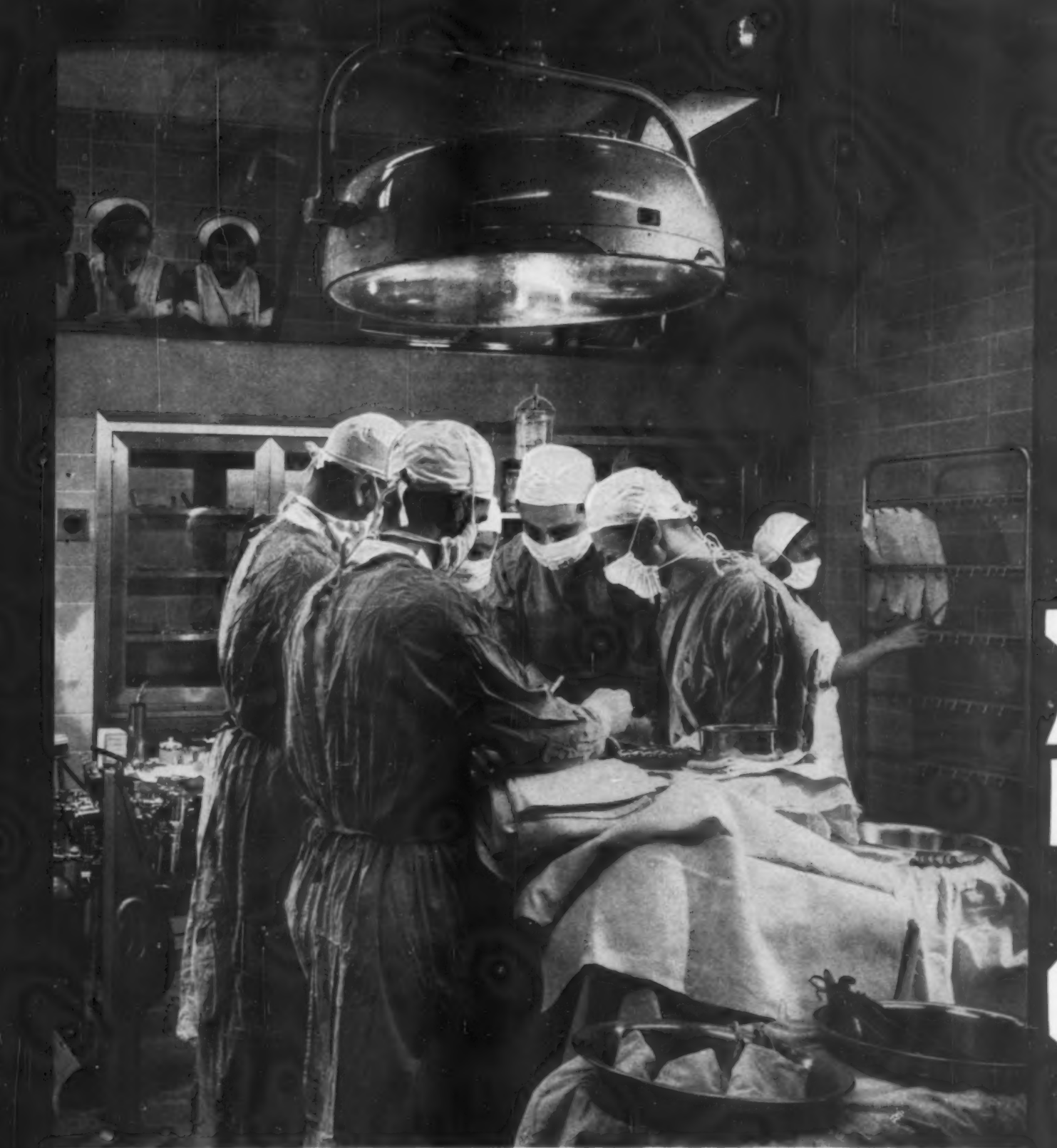

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(*Continued From Page* 96)

not delivered as ordered, it necessitates changing the menus.

6. Are stencils for all menus being retyped each week, increasing the work of the secretary?

Cooking Methods.

1. Are vegetables overcooked and cooked too far in advance? Also, are they left standing for periods of from one to three hours?

2. Are vegetables all being cooked at one time, causing crushing and unsatisfactory appearance and taste?

3. Are meats cooked at high temperatures, causing shrinkage and toughness?

4. Are steam kettles boiling over?

5. Are the cooks trained to use the French knife properly?

6. Are turkeys being cooked whole rather than boned and rolled, causing approximately 10 per cent more shrinkage?

7. Is there a planned use of leftovers? Are they being discarded, rather than refrigerated for reuse?

Observation of the decentralized floor kitchens also revealed certain practices that needed to be corrected. Some of these deficiencies include the following:

No training was given to new employes pertaining to serving patients, diets, sanitation or procedures of work. Each kitchen may be observing different work procedures. If there is no order for preparing trays, kitchen maids may, for example, take silver in each hand and then stoop and bend to place it on trays in racks. This procedure was also seen in placing salads and desserts. Maids may be using two motions instead of one to put vegetables or meat on the plate.

Food was being wasted. For example, juice, Sippy cream, and nourishments were left in refrigerators more than three days, and then poured out; extra food, such as peach halves, sliced pineapple, meats and vegetables, were poured into the garbage disposal unit; bread was left in re-

(*Continued on Page* 104)

Left: Series illustrates three steps in controlling food supplies. Top: First step is figuring the recipes in the quantity needed. The storeroom (center) weighs the quantity figured in Step 1, and (bottom) the weighed materials are delivered to the cooks.

8 second magic in I.V. set-ups

remove metal seal and disc

plug set into center of stopper with a quick thrust

quickly invert bottle to visually check for vacuum and to automatically establish fluid level in drip chamber; clear tubing of air and infuse

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The Saftisystem takes just 8 seconds to set up. There's no searching for the point of entry as there's only one place in the stopper where the set plugs in. The bottle, when inverted, automatically establishes a level in the drip chamber, and the incoming filtered air bubbling up gives a visual check for vacuum.

Medication can be added (aseptically) either before or after the flask has been suspended on the T stand, even after infusion is started.

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I. V. SET-UP

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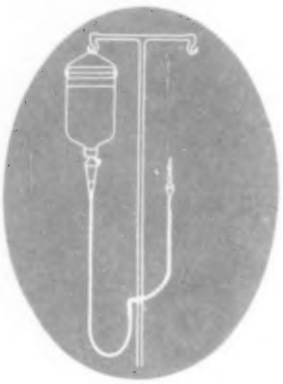
The rubber stopper is exposed and the set plugged in with one thrust. Then bottle is inverted to automatically establish a fluid level in drip chamber. Tubing is cleared of air. Takes about 8 seconds.



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frigerators and then thrown away, and eggs were scrambled too early for delayed trays.

If a shortage occurred, serving girls had to stop serving and return to the main kitchen for extra food.

Girls were not cleaning carts, and garbage disposal units and dish machines were not being used properly.

Following observation and study of existing conditions, the hard work began when our schedule called for pushing each change through as rapidly as possible. Over a period of three months the most drastic steps were made after we fully indoctrinated the staff and personnel to impending changes. The following are the most important changes we instituted.

Established Controls

The enormous amount of wasted food we found required some controls. We decided the ingredients must be weighed out in the storeroom after the final tally of the next day's census. Scales and measures were set up in the storeroom and one person was designated to weigh all ingredients in the quantity needed for each recipe. At the beginning of the program this person also did the figuring of the recipes, but later this duty was given to the kitchen supervisor.

Delays in the early morning caused some discontent among the cooks until corrections could be made in the program. Two additional persons were shifted to the storeroom for all-day coverage in weighing orders seven days a week.

Now that ingredients are delivered to the cooking area, the cooks lose no more time waiting in the storeroom area for supplies. A double check for accuracy is available on mistakes (in the storeroom to check on the supervisor's figures and cooks checking against storeroom weights) and each group has a set of recipes. This operation was responsible for a major portion of the annual savings.

Quantity recipes were figured by multiples in the range of 25 to 700 servings in order to speed the figuring of quantities.

Storeroom personnel now delivers extra food to floor pantries when shortages occur during mealtime. This prevents a break in the serving routine. Previously the trip to the main kitchen took as much as 15 minutes of the pantry maid's time from serving patients.

Assigned Definite Shifts

Main kitchen employes were changed to definite morning and afternoon shifts in order to cover the entire day. Also, we scheduled definite vegetable preparation personnel to have charge of the vaults and thus save time for the cooks. Certain cooks were assigned to cook vegetables and trained to cook them properly. One less person was needed in the kitchen.

Dippers and scoops were issued to cooks with instructions on how to use them properly. This prevents such mistakes as 7 ounce salisbury steaks portioned by guess when 3 ounce servings were specified. An enforcement system was also set up.

The butcher was taught to bone and roll turkeys, thus saving the cooks' valuable time in slicing and increasing the yield approximately 10 per cent.

Loading of the hot carts was changed. Instead of the cooks taking the food to the cart area, we had the carts pushed to each food preparation area to be loaded. Later this was changed and the pantry girls came to the kitchen to load their own carts, enabling them to check more closely

the items needed. As a result the supervisors check during loading time, and all foods are hot when the cart leaves for the floor kitchen.

Excess foods sent to pantries on hot food carts are returned to the kitchen. Enough leftover bread ends were returned for all breading and fillings.

A thorough training program for all dietary employes and pantry maids was started.*

These changes were completed within six months in order to start the new fiscal year with fairly good control of food costs from the preparation of food to the proper size portion to be served by the pantry maid. During the rest of the calendar year additional changes were instituted to complete the reorganization.

Changed Modified Diet Plan

The preparation of modified diets was completely revised. Formerly the food for the 225 to 240 modified diets was prepared in the small kitchen. Food preparation was shifted to the main kitchen and the cooked foods are loaded on the carts as the pantry maids push them by the loading areas. Cooked desserts, cakes, cobbler and puddings for the modified diets are furnished by the bakery department. This shift of diet food preparation eliminated the need for two kitchen employes.

Instituting a general inventory and issuing supplies to ward kitchens by estimated weekly quotas resulted in considerable savings and less work for storeroom employes.

The responsibility for perpetual inventory stock records of dry goods was changed from purchasing to dietary. A closer check of stock items is maintained, which virtually eliminated menu changes because of shortages in general stores.

Purchasing procedures were revised. Meat is purchased by the week instead of daily; vegetables are bought three times a week instead of daily, and general stores are ordered twice a week instead of three times. This has resulted in less paperwork and fewer menu changes because of late deliveries.

Job schedules were prepared for food production managers, food service supervisors, and all kitchen personnel in sanitation. An administrative supervisor was assigned the responsi-

*For a report of the training program see Stanfield, Peggy S.: Reward of Good Training Is Good Workers. Mod. Hosp. 92:138 (June) 1959.

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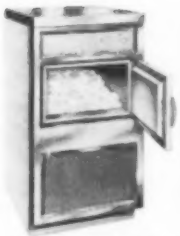

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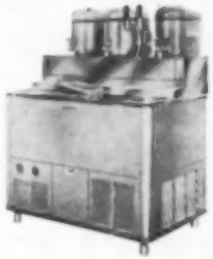

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bility of checking linens and uniforms to and from the laundry.

Linen napkins and tray covers were purchased for use in certain areas to replace paper. This resulted in some $2500 savings after original purchase price.

A three-week rotating menu plan was developed. Stencils are saved so the typist does not have to retype menus each week.

We started to serve early morning coffee to the patients in the private pavilion.

The last major change was in the serving of special nourishments. Previously they were delivered once each day, or every 24 hour period, and stored in the ward pantry refrigerators. A special kitchen was set up for preparation of nourishments, which are put in individual glasses, labeled for the patient, and served three times daily by dietary employes.

Found Added Savings

Among the direct savings resulting from the program was a decrease in food costs from $374,898.63 in 1956-57 to $352,592.49 in 1957-58, for a savings of $22,306.14.

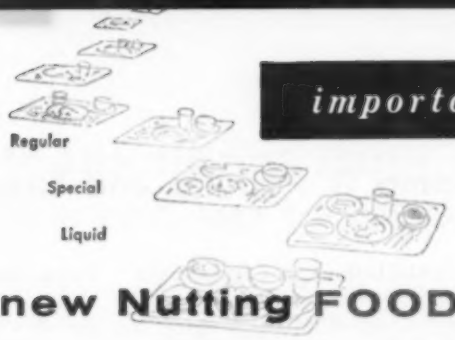
Savings from the use of linen instead of paper napkins and tray covers totaled $2500 after original purchase price. The new system of serving nourishments directly to the patients resulted in a savings of $7,137.42 over the previous year.

Increased costs which the hospital would have incurred if the dietary service had not been reorganized include an increase of $41,954.04 in meat prices over that of the previous year, according to the bid sheets. Instead, the hospital's monthly cost of meat remained stable, in direct contrast to the rising price of meat. Also absorbed was a sharp increase in the price of orange juice, which under the old system would have cost the hospital $8320.

In addition to these increased costs which were absorbed by the savings under the new program, the hospital spent an estimated additional $10,000 for products which were previously received as government surplus commodities. This increase was also absorbed.

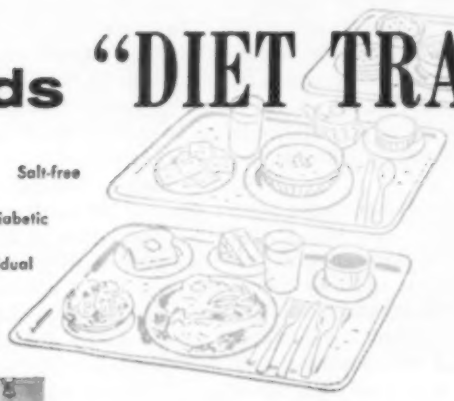
Finally, quite apart from the dollar savings, the program showed savings in labor of 11 per cent man-hours for main kitchen personnel; 18 per cent for custodial workers, and 11 per cent for food service workers. ■

important FOOD SERVICE news



The all new Nutting FOOD-*ala*-CART System

ends "DIET TRAY CONFUSION!"



Here for the first time is a food service system that ends one of the biggest problems facing dietitians . . . "Diet Tray Confusion." FOOD-*ala*-CART is the first and only food service system to provide *one oven drawer* for *every serving tray!*

This exclusive FOOD-*ala*-CART feature ends "Diet Tray Confusion" and makes spot checking easier—more accurate. It also speeds tray assembly—makes it simpler.

PATENT APPLIED FOR

Dietitians who have seen the FOOD-*ala*-CART system say it's the easiest to use equipment they have ever seen. Its design is based on a comprehensive research study among dietitians. These dietitians told us it's not the fixing of the food but the serving that is the big problem. The Nutting FOOD-*ala*-CART answers the serving problem best because it simplifies it, ends "diet tray confusion," keeps foods appetizing, refreshing, delicious tasting right to the patient. It is truly *the new standard of fine food service for hospitals.*

Only the new FOOD-*ala*-CART system offers *all* these features!

- ONE OVEN DRAWER FOR EVERY SERVING TRAY ends "diet tray confusion." It's the easiest to use food service system you have ever seen.
- FROZEN FOOD SECTION keeps frozen desserts served in sliced form, in ramekins or similar containers *frozen;* even ice cubes won't melt.
- ALL FOODS are served at dietetically accepted temperatures for maximum patient "meal appeal."
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Everyone is happier with FOOD-*ala*-CART! Patients, physicians, nurses, aids *and* dietitians, *all* like the way FOOD-*ala*-CART eases preparation, keeps foods appetizing and simplifies serving.

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Shrimp Is Popular and Easy To Prepare

BREADED shrimp is a Friday night special welcomed by both patients and staff at Doctors Hospital, a 200 bed hospital in the Cleveland Heights section of Cleveland.* Head Dietitian Marian Caddy, who has directed the hospital food operation for the last three years, regards shrimp as an ideal choice for all patients not on special diets — usually about half of all servings.

"Shrimp is one of the most nutritious of all foods," says Miss Caddy. "They're high in protein, extremely low in fat content, and they contain quite a bit of iodine, along with such minerals as calcium, magnesium, phosphorus and iron. Equally important, shrimp is a food that almost everybody enjoys."

A typical Friday menu consists of tomato juice, breaded fantail shrimp and cocktail sauce, baked potato with butter, coleslaw, roll, fruit or dessert, and beverage. The raw food cost for all this runs about 50 to 55 cents, with five breaded shrimp accounting for about 35 cents of the total.

To save labor and preparation time, Miss Caddy uses individually flash frozen shrimp. These breaded fantail shrimp need no advance preparation; the separate shrimp do not even require thawing but are cooked directly from the carton. This frees kitchen help for other chores.

Miss Caddy also likes the fact that the frozen shrimp come graded to exact size, which makes portion control simple.

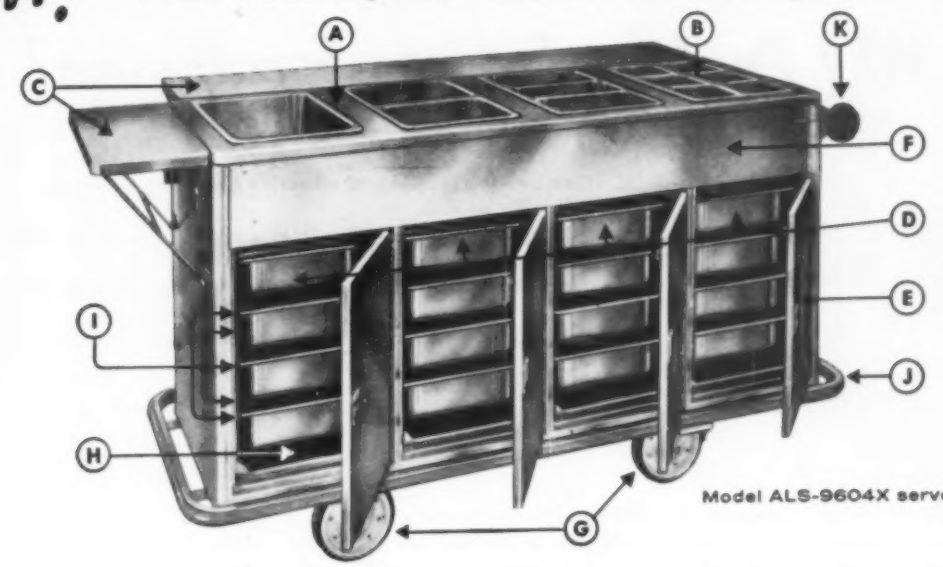
When breaded shrimp is on the menu, 100 meals can be prepared and served within an hour, extra fast time compared with other entrees, she reports. The fry cook merely opens the packages, drops the individually frozen breaded shrimp into a deep fat fryer, and cooks them 3 minutes at 350 F. in hydrogenated vegetable shortening. The breaded shrimps are never cooked ahead and warmed, but rather are prepared at the last minute and are served immediately to the patients.

Since the patients do not have a choice of entrees, and because it is so important therefore to plan menus with complete acceptance, Miss Caddy spot checks the returning trays to determine the taste preference of patients. And she is sure about one thing — shrimps don't come back! ■

*Since this article was prepared, Miss Caddy has left Cleveland. She is now living in Fayetteville, Ark.

Breaded shrimp go directly from deep fat fryer to hospital serving cart. This entree can be prepared and served to 100 patients within an hour.

New! Institutional Bulk Feeder Serves up to 300 Meals per Load!



Model ALS-9604X serves 300

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Model ALS-7203X serves 200

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E **COMPARTMENTS ARE FITTED WITH DOUBLE WALLED, INSULATED DOORS**, hung on continuous piano hinges, spring actuated, with finger-tip release latches.

F **TOP DECK HEATED WITH HI-FLO THERMOSTATICALLY CONTROLLED HEATERS** for quicker, more uniform heating.

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H **EXCLUSIVE BLICKMAN COVED CORNER CONSTRUCTION THROUGHOUT**—provides a smooth coved interior surface for easy cleaning.

I **STURDY REMOVABLE STAINLESS STEEL PAN RACKS.** Racks come out easily (no tools) leaving smooth interior for quick, easy cleaning. Pan slides are set to accommodate up to 6" deep pans.*

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K **STAINLESS STEEL PUSH HANDLES** mounted on stainless steel brackets, and protected by large donut type rubber bumpers—gives greater impact protection. Will not mar walls.

*Insets and pans available at extra cost.

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FOOD SERVICE EQUIPMENT

Why Purchase Food on Specification?

One avenue leading to effective food management is standardization of procedures, including food buying. This article discusses specifications for quantity and quality and how to present them so they cannot be misinterpreted

G. William Peffers

EFFECTIVE food management should determine accurately the quantities of food products that must be purchased so that, as nearly as possible, the exact number of servings or portions needed will be prepared, and no more. To determine the quantities accurately, it is essential to know the yield that can be obtained from each product to be purchased.

The results from a kitchen test on any food product will indicate the yield. Such tests include butchering, cooking, canned or prepackaged food tests, and raw food tests. The yield is usually expressed as the number of servings attainable or as a percentage of the total original weight of the product as purchased.

Thorough and accurate kitchen tests reveal three groups of data important to the daily food operations:

1. The relation of market prices paid to the final cost per serving.
2. The need for utilizing standards of portion size, recipes and cooking temperatures in food preparation.
3. Clearly defined standard food purchase specifications that have been developed on the basis of yield.

Kitchen tests are frequently used only for the cost data or for the determination of suitable preparation methods. The testing is too often halted after a single cost has been calculated or after a standard portion size has been established. When a test is stopped at this juncture, however, all of the factors related to proper yield are not considered and the information gained may be worthless at a future date. So, in addition to the valuable cost and preparation data, the kitchen tester should determine the most suitable grade, size or pack, variety and trim of the products tested. It is at this point that appropriate standard purchase specifications can be composed.

For example, the accompanying illustrations show the results of actual butchering tests. In each illustration the product that rendered the better yield was the one labeled "B," purchased under clearly defined, comprehensive specifications determined by previous testing. Specifications were indicated for the products labeled "A," but those specifications proved too general and incomplete.

Althought a specific weight range was shown, it was not stated specifically; hence it could be misinterpreted by the purveyor. The use of the word "average" in this specification could conceivably result in a weight range in any given shipment of from 4½ to 10½ pounds as long as the average was the specified 6 to 8 pounds. So, as did occur with the shipment of lamb rack "A," a 9 pound rack could be included.

The test results on lamb rack "A" were exceedingly poor as compared with rack "B." Even though a lower market price per pound was paid for lamb rack "A" as compared with rack "B," the latter showed the better yield.

In the comparison of two tenderloins, the basic difference between the two was in the percentage of suet content. Beef tenderloin "A," purchased under loose specifications, contained excessive suet as compared with the suet content on tenderloin "B." As a result the percentage yield was higher and the cost per usable pound was lower for tenderloin "B."

In any discussion which advocates a certain standard, at least one possible variable to the standard should be mentioned. There are many instances when the product best suited to the needs of the food operation is, in the final analysis, resolved down to a specific brand name. When this occurs, then the brand name and the pertinent factors pertaining to that brand should

With this issue we begin a series of articles on various aspects of food management prepared by G. William Peffers. Mr. Peffers is director of the dietary department at Michael Reese Hospital and Medical Center, Chicago. He is a graduate of the school of hotel administration of Michigan State University. He served as a management advisory services consultant with Harris, Kerr, Forster & Company prior to his assignment at Michael Reese.

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Fig. 1 —	Lamb Rack "A"	Lamb Rack "B"
Prescribed Purchase Specifications	U.S. Choice, fresh, 6 to 8 lbs., average.	U.S. Choice, fresh, 5½ to 7 lbs., each. Double rack, 8 ribs (5th through 12th ribs) to measure not more than 5 inches at loin end and 4 inches at blade end.
Actual Weight Received	9 lbs.	6 lbs.
Market Price per lb.	$0.52	$0.54
Weight After Butchering	4 lbs.	3 lbs., 8 oz.
Per Cent Yield	44	58
Cost per Usable lb.	$1.17	$0.93
No. of Chops	16	14
Cost per Chop	$0.29	$0.23

Fig. 2 —	Beef Tenderloin "A"	Beef Tenderloin "B"
Prescribed Purchase Specifications	From U. S. Choice steer, fresh, 6 to 8 lbs., average	From U.S. Choice steer, fresh, 6 to 8 lbs., each. Excess fat removed to expose gland approx. 6 inches from butt end, fat tapered not to exceed three-fourths of the length of tenderloin (approx. 30% or less fat by weight)
Actual Weight Received	6 lbs., 14 oz.	6 lbs., 12 oz.
Market Price per lb.	$1.50	$1.50
Weight After Butchering	3 lbs., 2 oz.	3 lbs., 12 oz.
Per Cent Yield	45	56
Cost per Usable lb.	$3.30	$2.70

be written into the standard specifications.

The success of standard food purchase specifications, like almost anything else, depends upon the guidance and follow-up exercised by management. The specifications should not be just set up and then left to do the job by themselves. Market conditions and food products change from time to time. New food products are continually being introduced. The established specifications should also be subject to change. Retesting of old products and new testing of new products should be included as standard procedures allied with the use of the original standard purchase specifications. ■

Menus for February 1960

Norry J. Lessard
Food Administrator
St. Luke's Hospital
Jacksonville, Fla.

1
Scrambled Eggs
Scotch Ham

•

Roast Round of Beef
Roast Potato
Cauliflower, au Gratin
Spiced Burton Plum Salad
Banana Cake

•

Onion Soup
Ham, Macaroni
and Cheese
Green Peas
Celery, Olives and Pickles
Chocolate-Pecan Tart

2
Pineapple Juice
Poached Eggs

•

Country Style Chicken
Yellow Rice
Quartered Beets
Perfection Salad
Tapioca-Peach Pudding

•

Cream of Chicken Soup
Baked Meat Loaf
Lyonnaise Potatoes
Tiny Whole Green Beans
Tomato Slices on Lettuce
Chilled Fruit Cocktail

3
Banana
Fried Eggs

•

Fried Liver, Onion Gravy
Mashed Potatoes
Sliced Carrots
Hearts of Lettuce With
Thousand Island Dressing
Bread Pudding

•

Cream of Celery Soup
Roast Leg of Veal, Gravy
Boiled Potato
Stewed Okra and Tomato
Waldorf Salad
Cherry Pie

4
Apple Juice
Sausage Links

•

Baked Virginia Ham
Scalloped Corn
Chopped Spinach
Cottage Cheese Salad
Ice Cream

•

Potato Soup
Chicken Pilau
Green Peas
Carrot and Raisin Salad
Hot Gingerbread
With Applesauce

5
Half Grapefruit
Hard Cooked Eggs

•

Fried Scallops, Tartare
Sauce
French Fried Potatoes
Eggplant, au Gratin
Coleslaw
Lemon Meringue Pie

•

Clam Chowder
Tuna Croquettes,
Pea Sauce
Mashed Potatoes
Baked Acorn Squash
Stuffed Prune Salad
Peaches in Lime Gelatin

6
Fried Eggs
Grilled Ham

•

Fried Chicken
Scalloped Potatoes
Glazed Whole Carrots
Spiced Apple Salad
Banana Pudding

•

Minestrone Soup
Creamed Chipped Beef
on Noodle Nests
Baked Potato
Buttered Spinach
Stuffed Celery Hearts
Date Nut Roll

7
Sliced Peaches
Scrambled Eggs

•

Roast Prime Rib of Beef
Mashed Potatoes
Creamed Green Peas
Under-the-Sea Salad
Ice Cream

•

Cream of Chicken Soup
Italian Meat Balls
and Spaghetti
Buttered Asparagus
Caesar Salad
Rice Custard

8
Orange Juice
Sausage Pattie

•

Roast Leg of Lamb
Baked Idaho Potato
Creamed Cauliflower
Sunset Salad
Butterscotch Pudding

•

Cream of Asparagus Soup
Beef Stew
Boiled Potato
French Fried Carrot Sticks
Tossed Green Salad
Apple Pie

9
Stewed Prunes
Grilled Scotch Ham

•

Broiled Chicken
Buttered Rice
Cut Green Beans,
Amandine
Grapefruit, Avocado Salad
Cherry Fruit Gelatin

•

Spanish Bean Soup
Breaded Veal Cutlet
Scalloped Potatoes
Buttered Spinach
Waldorf Salad
Peach Shortcake

10
Grapefruit Segments
Poached Eggs

•

Baked Canadian Bacon
Candied Sweet Potato
Broccoli
Cottage Cheese Salad
Bread Pudding, Raisin
Sauce

•

Puree Mongole
Chicken Chop Suey
Chinese Noodles, Rice
White Acre Peas
Carrot and Raisin Salad
Chocolate Meringue Pie

11
Banana
Crisp Bacon

•

Swiss Steak
Roast Potato
Mashed Rutabagas
Tomato-Cucumber Salad
Ice Cream

•

Cream of Mushroom Soup
Roast Loin of Pork
Applesauce
Baked Stuffed Potato
Scalloped Tomatoes
Perfection Salad
Cherry Cobbler

12
Blended Juice
Fried Eggs

•

Broiled Fillet of Haddock
French Fried Potatoes
Turnip Greens
Cabbage Salad
Lemon Meringue Pie

•

Manhattan Clam Chowder
Fried Fish Sticks
Baked Sweet Potato
Creamed Celery
Rosy Pear Salad
With Cream Cheese
Caramel-Pecan Cake Float

13
Scrambled Eggs
Crisp Bacon

•

Baked Virginia Ham
Home Fried Potatoes
Fresh Collard Greens
Congealed Spiced
Apple Salad
Pineapple Delight

•

Danish Cheese Soup
Fried Liver and Onions
Rice With Gravy
Asparagus
Lettuce Wedge,
French Dressing
Applesauce, Cookies

14
Sliced Peaches
Scrambled Eggs

•

Rib Eye Steak
Mashed Potatoes
Onions, au Gratin
Stuffed Celery and Olives
Ice Cream

•

Beef Noodle Soup
Tuna–Noodle Casserole
Buttered Spinach
Under-the-Sea Salad
Strawberry Shortcake

15
Pineapple Juice
Fried Eggs

•

Roast Turkey, Southern
Dressing
Giblet Gravy
Mashed Sweet Potato
Green Peas
Spiced Crab Apples
Rice-Raisin Pudding

•

Minestrone Soup
Broiled Beef Pattie
Potato Sticks
Yellow Squash
Lettuce and Cucumber
Salad
Apricot Cobbler

16
Rhubarb and Strawberries
Link Sausages

•

Roast Leg of Veal, Gravy
Boiled Potato
Harvard Beets
Stuffed Prune Salad
Nesselrode Pudding

•

Mulligatawny Soup
Sauteed Chicken Livers
With Mushrooms
Scalloped Corn
Fried Eggplant
Chef's Salad
Jelly Roll

17
Banana
Scrambled Eggs

•

Broiled Lamb Chops,
Mint Jelly
Scalloped Potatoes
Candied Whole Carrots
Hearts of Lettuce,
Russian Dressing
Applesauce Cake

•

Cream of Chicken Soup
Beef Steak Pie
Buttered Noodles
Asparagus
Tossed Green Salad
Baked Indian Pudding

18
Fried Eggs
Grilled Ham

•

Broiled Chicken
French Fried Potatoes
Cauliflower in Tomato
Sauce
Mixed Vegetable Salad
Iced Cake Square

•

Cream of Asparagus Soup
Ham and Veal Loaf
Home Fried Sweet
Potatoes
Blackeyed Peas
Perfection Salad
Ice Cream

19
Purple Plums
Hard Cooked Eggs

•

Shrimp Creole
Rice
Fried Parsnips
Cucumber and
Pimiento Salad
Lemon Meringue Pie

•

Red Snapper Chowder
Salmon Croquettes
Buttered Grits
Baked Acorn Squash
Pineapple-Cottage
Cheese Salad
Devil's Food Cake

20
Banana
Crisp Bacon

•

Country Fried Steak
Duchess Potatoes
Sliced Beets
Sunset Salad
Baked Apple

•

Vichyssoise
Breaded Veal Chop
Roast Potato
Tiny Green Lima Beans
Tomato Aspic on Lettuce
Frozen Whole
Strawberries

21
Half Grapefruit
Fried Eggs

•

Roast Turkey, Gravy
Corn Bread Dressing
Mashed Potatoes
Green Peas
Spiced Whole Peach Salad
Ice Cream

•

French Onion Soup
Broiled Canadian Bacon
Delmonico Potatoes
Asparagus
Grapefruit-Avocado Salad
Lemon Cake Float

22
Orange Juice
Bacon

•

Baked Stuffed
Cabbage Roll
Lyonnaise Potatoes
Whole Kernel Corn
Chiffonade Salad
Tapioca Pudding

•

Split Green Pea Soup
Veal Pot Pie
With Dumplings
Tiny Whole Green Beans
Chef's Salad
Apple Pie

23
Poached Eggs
Broiled Scotch Ham

•

Pot Roast of Beef,
Jardiniere
Oven Brown Potatoes
Yellow Squash
Piquant Salad
Ice Cream

•

Cream of Tomato Soup
Chicken a la King
on Melba Toast
Green Peas
Lima Bean Salad
Boston Cream Pie

24
Prune Juice
Scrambled Eggs

•

Breaded Veal Cutlet
Baked Idaho Potato
Stewed Tomato and Okra
Pear and Yellow
Cheese Salad
Coconut Chiffon Pie

•

Navy Bean Soup
Scalloped Hamburger,
Macaroni, and Tomato
Harvard Beets
Winter Vegetable Salad
Baked Apple,
Whipped Topping

25
Grapefruit Segments
Fried Eggs

•

Broiled Chicken
Mashed Potatoes
French Fried Onion Rings,
Stuffed Celery
Pineapple Upsidedown
Cake

•

Vegetable Soup
Baked Meat Loaf, Creole
Macaroni and Cheese
Peas and Mushrooms
Sunset Salad
Caramel Pecan Tart

26
Applesauce
Scrambled Eggs

•

Fried Shrimp, Tartare
Sauce
French Fried Potatoes
Scalloped Eggplant
Tossed Green Salad
Corn Bread
Peach Shortcake

•

Oyster Stew
Broiled Salmon Steak
Boiled Potato
Buttered Cabbage
Waldorf Salad
Chocolate Meringue Pie

27
Pineapple Juice
Link Sausage

•

Swiss Steak
Lyonnaise Potatoes
Fried Cauliflower
Under-the-Sea Salad
Orange Cake Float

•

Lima Bean Soup
Grilled Pork Chop,
Applesauce
O'Brien Potatoes
Fried Carrot Quarters
Beet Salad
Florida Fruit Compote

28
Stewed Apricots
Scrambled Eggs

•

Roast Turkey,
Southern Dressing,
Gravy
Cranberry Sauce
Mashed Potatoes
Tiny Whole Onions
and Mushrooms
Sliced Orange-Date Salad
Ice Cream

•

Chicken Noodle Soup
Corned Beef Brisket
Buttered Grits
Tomato and
Cucumber Salad
Date-Nut Roll

29
Orange Juice
Scotch Ham

•

Roast Top Round of Beef
Roast Potatoes
Cauliflower, au Gratin,
Spiced Burton Plum Salad
Banana Cake

•

French Onion Soup
Scalloped Ham,
Macaroni and Cheese
Buttered Green Peas
Celery, Olives and Pickles
Chocolate Pecan Tart

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The Evidence Favors the Hospital Laundry

The hospital that runs its own laundry instead of having it done commercially has better control of linens and can give better service to patients and staff, particularly in emergency situations, this study shows

Louis Block, Dr. P.H.

WHETHER a hospital should operate its own laundry or not must be decided not only by the economics of the problem but also by those important factors that affect patient care. The problem can be solved only by a careful evaluation and weighing of both types of service, *i.e.* hospital operated or commercial.

Here is the case for hospital laundries as analyzed by hospital groups. The hospital operated laundry:

1. Provides absolute control over all linens.

This holds true from the standpoint of inventory controls, disbursement controls, laundering process controls, and replacement controls.

2. Eliminates mixups and delays caused by outside handling.

When laundry is done on the hospital premises there is no need for transportation to and from the outside laundry source. Such transportation is affected by traffic problems and traffic movement. Transportation is a costly overhead item.

3. Can handle special rush demands from any department.

When laundry is done on the premises, the necessary decisions in the event of rush demands are made by the hospital staff. Only hospital problems enter into consideration.

4. Requires less linen in circulation and therefore less inventory and investment in inventory.

It is an accepted fact that there is need for more linen and a greater inventory when laundry is done commercially. The lowest estimates indicate that a minimum additional inventory of 20 per cent is needed. This additional inventory has amounted to 300 per cent of original inventory in some instances. The average estimate is a 50 per cent increase in inventory.

5. Gives better control of week-end needs and deliveries.

The hospital has more flexibility within its own operating policies in this respect and can plan for these needs on a more flexible basis.

6. Lessens the possibility of shutdowns and interruptions in service caused by labor problems.

Even though such happenings may be infrequent, the possibility that they may occur has to be taken into consideration. If such problems led to industrywide involvement, it would be extremely difficult, if not impossible, to make other commercial arrangements for this service. If the service is performed on the hospital premises it is much easier to meet such a situation on an emergency basis.

7. Gives better control over reuse and discarding of linens.

Although this point has been mentioned as an advantage to the hospital with its own laundry, its validity can be questioned in that it is possible for the individual hospital to decide this even when the service is performed by a commercial concern.

8. Gives better quality control because it handles only hospital linens with their own stain removal problems.

Although outside groups may argue that experience with a wider range of dirt problems makes a concern more competent in handling all problems, a greater degree of specialization in those problems confronting hospitals is possible when the service is limited to one consumer group as it is with a hospital laundry.

9. Furnishes opportunities for self-control over operating costs.

The hospital will have much more to say about controlling operating costs when it provides its own laundry service. In fact, when dealing with a commercial concern, the hospital has no say as to how the concern should handle its control of costs.

10. Eliminates need for contract negotiations.

This is a statement of fact inasmuch as the hospital is not confronted with the question of profit.

11. Is independent from outside sources during emergencies.

Evidences of this value were demonstrated during the last war.

Here is the case for the commercial laundry. Commercial laundry concerns have claimed that they are able to provide a better service because they have a greater variety of equip-

At the time this article was prepared, Dr. Block was chief of the Research Grants Branch, Division of Hospital and Medical Facilities, Public Health Service, Washington, D.C. He is now affiliated with Gordon Friesen Associates, Inc., hospital consultants, Washington, D.C.

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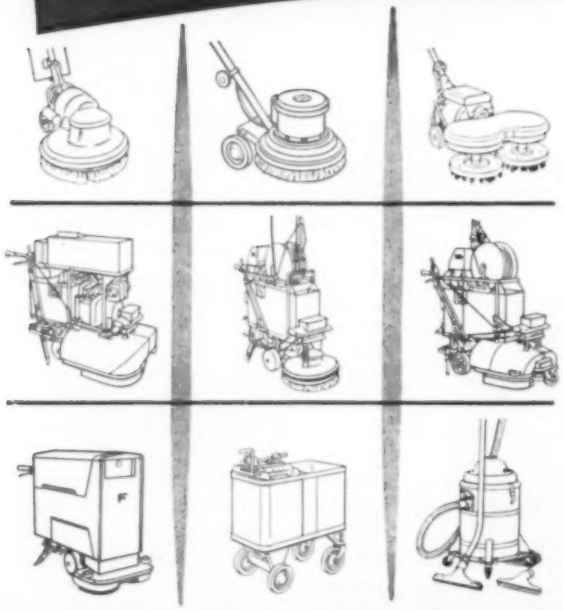

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points presented should give us some insight into the validity of these statements.

1. Hospitals sometimes fail to consider the cost for freight and installation of laundry equipment in their planning and estimating.

This implies that hospital planners, including architects and consultants, often neglect to consider such costs in estimating needs. This is generally not true.

2. Hospital management faces a continuing problem in buying laundry supplies wisely because of local washing formula needs and the combination of supplies needed to produce this formula.

This implies that hospital laundry managers and administrators are incapable of determining their needs and that the services necessary to determine these needs are not available to them. This also is not true. Hospital laundry equipment manufacturers provide this service to hospitals as they do to private commercial laundries.

3. Hospitals will have difficulty in recruiting and training personnel for laundry work.

This is no more true for the laundry than for any other service. Hospitals are providing inservice training programs to reduce this problem. Commercial laundries are faced with the same problem resulting from personnel turnover. It is a fact that hospitals have a greater tendency to use inservice training programs than do some of the smaller commercial concerns.

4. Hospitals have a tendency to buy too much equipment, thereby making depreciation costs unreasonable, or they buy too little equipment, which slows up service.

This may be true where there is improper planning. However, the statement as presented is a rather broad general one and without too much basis in fact.

5. Laundry equipment in hospital laundries calls for extra maintenance.

This implies that the need for maintenance is peculiar to hospital laundries and not to commercial laundries. Economics alone would dictate that the commercial laundry takes maintenance costs into consideration in setting its pricing schedules.

6. Hospital reputation is largely dependent on appearance and service. When linens are professionally laundered, hospitals should be able to count on better reputation and higher income through assured room occupancy.

This statement tends to imply that hospital laundries are not "professional" in their work performance. This is definitely not true. There is no question that clean, fresh linen is an important factor in the psychological aspects of patient care; however, this alone does not ensure good public relations or a high level of occupancy.

7. Hospital personnel will tend to use linen more economically when it is sent out for laundering.

Studies do show that when outside laundering is used, less linen per patient-day is used. However, no definitive studies have been made to show whether such lower utilization is a result of availability of linens, inability to meet special departmental requirements, or the cost involved.

8. Sending laundry out eliminates expensive "free laundry service" that employes often will take advantage of.

This may be true. However, the application of proper controls could avoid the abuse in the hospital laundry.

9. Costs of administration are much greater than is ordinarily realized by the hospitals.

This implies that the commercial laundry is perhaps not faced with these same administrative costs, such as purchase and follow-up of supplies, keeping records, paying bills, maintaining payrolls, interviewing prospective employes, and preparation of reports. An adequately operated commercial laundry must include these administrative costs in establishing price schedules.

The foregoing analysis seems to stress the "salesmanship" approach. The decision of a hospital to do its own laundry or not must be based on economics, the need for control of infection, and the availability of linens when and where they are needed in the amounts needed.

In order to answer some of these questions of cost, special studies were made in hospitals in Connecticut and in New York. The tables at left show results of these studies.

The variations noted are owing primarily to the amount and kinds of laundry other than flatwork that is performed in these individual hospitals.

The median cost per pound at the eight Connecticut hospitals — which includes all possible costs — was $0.092 per pound; the median cost per patient-day at the 14 New York hospitals was $0.67.

It appears evident that a commercial laundry can perform a better service at a lower cost when compared with the operation of a poorly planned and inefficiently operated hospital laundry. The same holds true in reverse — a well planned and efficiently operated hospital laundry should be able to perform as well at a lesser cost than a well planned and operated commercial laundry. This is so because the hospital laundry can operate on a nonprofit basis and a commercial enterprise cannot. In addition, the hospital laundry, as previously mentioned, has the advantages of needing a smaller linen inventory, less transportation between source of supply and the patient, and less counting of linen in the processing. These factors tend to inflate the cost of service purchased commercially. ■

Laundry Cost at Eight Connecticut Hospitals

No. of Beds	Cost per Lb. Processed*
733	$0.089
622	$0.081
578	$0.096
386	$0.097
370	$0.073
368	$0.113
345	$0.114
366	$0.075

*These costs include cost of linen and replacement, depreciation and all indirect charges such as overhead. They also include the cost of laundering all items including uniforms, spreads, blankets and so forth.

Laundry Cost at 14 Hospitals in Rochester, N.Y.

Hospital	Cost per Patient-Day*
1	$0.44
2	$0.94
3	$0.64
4	$0.52
5	$0.59
6	$0.89
7	$1.20
8	$0.70
9	$0.57
10	$0.94
11	$0.44
12	$0.80
13	$1.03
14	$0.55

*These are direct costs only of processing all linens, including uniforms.

Results of two studies of laundry costs in Connecticut and New York.

Housekeeping Lessons Come From London

American housekeepers who think they have troubles may take comfort and learn some useful lessons from this account of the problems involved in organizing the housekeeping department in a 200 year old London hospital

Octavia Snow, O.B.E.

IN OCTOBER 1956 I was appointed to the staff of The London Hospital with the title of Household Organiser. The task of reorganizing the domestic services of the hospital continued until 1959. At the time it was begun the major problems faced by the hospital management were:

1. Shortage of staff.
2. High turnover of labor.
3. Poor standard of work.
4. The need to relieve the matron's staff of administrative duties for a department unrelated to nursing.

The London Hospital is one of the largest teaching hospitals in Great Britain, comprising a general hospital of more than 1000 beds, of which some 700 are located in the main hospital buildings, while the remainder are in the annexes and other subsidiaries. Attached are the medical college, dental school, nurses training school, and schools of radiology, midwifery, physical therapy and practical dietetics.

The hospital also has a large research center and is the seat of the Department of Research in Industrial Medicine in association with the government financed Medical Research Council. The outpatient department of the hospital alone served 683,778 patients in one year.

Situated close to the dock area of London, and established more than 200 years ago through the inspiration of seven men who raised 100 guineas to equip and open an "infirmary" in 1740, it has been busy growing in size and reputation ever since.

It is not difficult to picture the formidable problems of cleaning which have arisen with 200 years of structural additions and modifications. Within one single wing of this vast establishment one can, so to speak, go from the sublime to the ridiculous: from streamlined, up-to-the-minute laboratories on one floor to a maze of small, old-fashioned rooms on the next, from newly designed wards at one end of a corridor to elderly structures earmarked for replanning at the other.

And, to provide the ultimate confusion for those responsible for cleaning, are the continuous activities of demolition gangs and builders as the major rebuilding program proceeds alongside the daily hospital work, or, as it seems to those of us intent on repairing the ravages of brickdust and building debris, often not only alongside, but in our midst.

From my preliminary survey of the task, it appeared that the problems of reorganization of my department fell into the following main categories:

1. Recruitment of an efficient administrative and supervisory staff, or, failing this, staff of a quality capable of being trained.

(*Continued on Page* 124)

Before she became household organizer of The London Hospital, Mrs. Snow had engaged in personnel management, served six years in the Women's Royal Naval Service as an administrative officer, and five years as national secretary of the British Legion Women's section. She filled her spare moments working on various committees connected with social welfare, Mrs. Snow explains, which is why she had "the audacity to crash into the hospital world and now express my views on how they should manage their affairs."

Octavia Snow

Tissue was the issue... costs the consideration

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America's Most Complete Line of Paper Towels, Tissues and Napkins

(*Continued From Page* 122)

2. Establishment of an adequate and stable domestic staff.
3. Development of satisfactory staff relations.
4. Replanning of work schedules.
5. Introduction of modern labor saving methods.
6. Training of staff.
7. Reduction of overtime costs.

During those early months an immediate response was created by the simple expedient of showing the workers that one was sincerely interested in them as people, desirous of bettering their conditions of work, and respecting them as responsible, reasonable individuals.

I would stress to those who are in positions where hard cash for complex schemes and costly equipment are not yet forthcoming that the development of sound personal relationships can, in my opinion, achieve more than the most lavish capital expenditure on equipment will ever do. As my work proceeded, I was lucky enough to achieve the equipment, also, but I am fully aware that the foundations were laid in those early days when the employes were made to feel that they mattered as people, rather than as so many units of labor.

Made Simple Adjustments

Starting with the most elementary improvements, it was during these early days that we made the simple and inexpensive adjustments which were found desirable. They were based on a considerable amount of thought and observation, and were to contribute considerably to the comfort and well-being of the staff, yet individually they involved very small cost and may seem trifling. Tall workers using standard length broom handles were working under quite unnecessarily tiring conditions, and were surprised and grateful for the issue of brooms to fit them. Large buckets were unnecessary and the issue of a smaller size made a noticeable difference in their weight, as well as ensuring that water was changed more frequently during the cleaning process. The changeover from hand scrubbing to long-handled deck scrubbers not only got the employes off their knees, but reduced the time and fatigue engendered by old-fashioned methods.

Needless to say, there was a small group of diehards who scorned such technics, and these were quietly left to their own devices. New methods were thrust upon no one other than the newcomer, but within 12 months even the most scornful had succumbed to the new ideas, and improved methods of work and maintenance of their equipment had been achieved.

With the shortage of labor and the rising cost of wages, it was evident that we must mechanize all possible processes and thus reduce the time factor, while at the same time making the work more congenial to the potential employe.

Mechanical Aids Needed

One of my early tasks was, therefore, the study of all possible designs of mechanical equipment suitable for hospital cleaning. A highly developed capacity for sales resistance proved to be a prerequisite for such investigation. Forgetting all one knew about those handy domestic aids one had used for years in one's own home, closing one's ears to familiar trade names whose market was primarily the family household, and steeling oneself against the blandishments of zealous salesmen, one needed to pause at intervals and repeat the formula: "size, quietness, robustness, simplicity, mobility and stowage."

It should be obvious that machines destined to operate in the large areas of hospitals should have large fittings to cover the ground effectively and quickly, yet how many times I have observed polishers and vacuum cleaners designed for the small modern home being used for large-scale cleaning in hospitals.

The absence of noise is, or should be, a major factor in one's choice, for, unless we are to drive our patients to distraction, we must have the maximum quietness. Here, however, we come across a major pitfall, for so many of the small industrial machines suitable to our purpose have been designed for the office building or factory, where the cleaning is done when the buildings are empty and noise is relatively unimportant.

The general robustness of the machine and the quality of the engine is a further point to be watched, as machines suitable for our purposes must stand eight hours' usage a day for polishing and scrubbing machines, and six hours a day for vacuum cleaners in general use around the hospitals. The only zones in which a shorter running day had to be accepted were the wards, where a vacuum cleaner is allocated to each ward, because, in accordance with hospital routine, the majority of vacuum cleaning takes place at the same time, so that interchange of machines is not possible.

Bearing in mind the limited skill of many of the staff workers who are called upon to handle machinery, I have also aimed at purchasing machines of simple design, free from too many gadgets or complicated fittings. Our machinery must be moved from one location to another, and all our operaters are women, so mobility and ease of handling have been important factors.

Finally, there was the question of stowage. This can present a very real problem in hospitals designed in the broom-mop-and-bucket era which may well find difficulty in creating space for large quantities of machines unless they are compact. In fact, in making my final selection, I had to forego what in other respects appeared an excellent machine because it required nearly two feet more storage space than another make. Not perhaps much of a problem if one only required one machine, but quite necessary to consider if you intend buying six.

Equipment Kept in Use

In giving the running hours of machinery, I should point out that the work span of the domestic staff is from 7 a.m. to 9:30 p.m., with the laboratories, lecture rooms, offices, corridors and canteens being cleaned by an evening shift. I also find it necessary to stress to one's staff the fact that machinery represents capital investment and so long as it remains standing in a corner unused it is not earning its keep. This basic economic principle, so clearly recognized in industry, tends to be overlooked in hospitals, and employes seem to feel that they are achieving some praiseworthy objective in "saving equipment from wearing out," whereas they are, of course, only tying up unnecessary capital which might be invested more usefully elsewhere.

With the introduction of mechanical polishers, scrubbers, dryers and so on, the need to ensure careful mainte-

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Sam Swetnam, Owner, ECONOMY STEAM LAUNDRY, Victoria, B.C., Canada: "I'm saving $10,000 annually! Quality much better. We saved 40% in floor space. Our washroom staff is cut 40%. And the machines wash cleaner and extract drier in less time."

R. George King, Owner-Mgr., ACME CLEANERS-LAUNDRY, Fort Smith, Ark.: "I installed two 200-lb. Glover Washer-Extractors two years ago. I have had my new 100-lb. in operation two months now. They do an exceptionally fine job on linen, industrial laundry, shop towels or family bundles.

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nance of machinery and skill in usage caused us to establish teams of women known as "mechanical operators" and remove from the individual wards the responsibility for basic floor maintenance and the high dusting of lobbies, sluice rooms, and so forth.

In many areas we have very high ceilings which the ordinary worker is unable to reach with normal equipment. The mechanical operators have a special type of vacuum cleaner with aluminum extension rods that are light enough to allow them to reach these difficult areas. The day team now covers all wards for basic scrubbing, laying of polish, buffing and high dusting. Under their team leader these employes comprise a self-contained unit, and having once established a basic weekly program in consultation with the household superintendent, the team leader deals directly with the ward Sisters.

Leader Reassigns Workers

Should a ward find it inconvenient to have the team on its allotted day, the team leader reallocates her workers, either to another ward, in consultation with the Sister, or to outside duties such as corridors, library or staircases. This is done without referring back to the household superintendent, and we find that much time is saved that the team would otherwise spend waiting around while she was being consulted and adjustments were made. The employes on these teams wear distinctive uniforms and can, therefore, be easily identified by a busy ward Sister when they enter her ward.

The ward domestic assistants, relieved of the basic floor maintenance, are only responsible for the daily routine of sweeping and dusting, and the rebuffing at intervals throughout the week, depending on the particular condition of each ward. For this purpose two electric polishers are kept, which are drawn as required. The poor condition in which these machines are maintained illustrates the value of keeping the greater part of the machinery in skilled hands.

By employing the daytime team in this way, we were able to ease the burden of the ward domestic assistants, allowing them in turn to assume duties that otherwise fall on the junior nurses. We also found that we could reduce the wasteful use of costly materials that are only required by the mechanical operators, who receive special training in their use.

The evening team is mainly employed scrubbing large areas of floor in such departments as the x-ray department, the lay staff canteen, and the maintenance of corridors, both polishing and high dusting. Although one set of machines must be shared between the two teams, all spare parts and fittings are issued in duplicate so that friction does not arise between teams because equipment has been damaged or put away dirty by either group.

Adopted New Polish

While The London Hospital, in the newer sections, has a wide selection of modern floorings of various kinds, the major part of the hospital floor covering is linoleum. When I was first appointed, this was either wax polished or, in areas where there was fear of patients slipping, such as in orthopedic wards, scrubbed regularly. This certainly avoided the slip hazard but was damaging to the linoleum. Over the years such treatment created a surface that became increasingly difficult to keep clean, and, in addition, involved heavy labor costs as at that time it was scrubbed by hand.

After extensive testing of a wide selection of materials, we found a new product in the form of a plastic emulsion polish. This not only provides a highly satisfactory nonslip surface and excellent finish, but has to be relaid only every 12 or 14 weeks. Previously, relaying had been carried out fortnightly, or in some cases, weekly. Despite the higher cost of material, we showed a useful saving in view of the smaller quantity that is required. It is also laid with a special long-handled spreader that has also saved some 25 per cent of the time previously spent in this process.

Employe Training

Finally, I come to the question of training. The major handicap with which I had to contend was lack of adequately trained administrative and supervisory staff and it took two years to achieve a group capable of doing more than just keeping the boat afloat. When we finally reached a relatively stable position with regard to the administrative group, our aim was to establish a training program for ward domestic assistants and the mechanical operators, which included instruction for all new staff members and refresher courses for established workers.

This program consists of classroom practical demonstration in the use of equipment, instruction in use of materials, talks on the patient-staff relationship, and a brief history of the hospital in order that the newcomer might develop a sense of belonging to the hospital rather than being only employed by it.

After the classroom instruction, the trainee would then be placed on a selected ward as a supernumerary for one week, still under the supervision of the instructor, and in the care of experienced ward domestic assistants, after which time she would be placed in a normal ward vacancy. The refresher courses for established staff would have to be limited at first to half a day, and would aim at developing its knowledge of modern technics and materials; at the same time, by diplomatic approach, we would attempt to eradicate faulty and obsolete methods of working.

Overtime Costs Reduced

Needless to say, the combination of a more contented staff and the easing of the heavier and more unpleasant work by the introduction of mechanical aids resulted in major reductions in absenteeism, sickness and turnover of staff. Comparative figures for the years 1957 and 1958 showed a 50 per cent reduction in absenteeism and 20 per cent in resignations. To give the full sickness figures would provide a false and excessively favorable figure owing to the serious influenza epidemic in 1957 when we lost as many as 133 workdays in a single week, but the general trend for the rest of the year was encouraging, and showed an approximate reduction of 45 per cent. Overtime costs were reduced by two-thirds of that in 1957.

These favorable developments coincided with a period when legislation came into force which reduced the weekly hours for hospital domestic staff workers from 48 hours to 44 hours. Yet, we managed to adjust without any increase in staff, despite losing some 640 hours of work a week. This, I think, helps to illustrate the advantages that accrued when we "put our house in order." ■

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This Study Matches the Nurse to the Job

(*Continued From Page* 79)

In discussing all of these characteristics, it should be remembered that each of the vocational elements in this study is dependent in some measure upon the other 44. Each of the findings may have its own significance, greater or lesser, but it is only when they are combined that a fully meaningful pattern is formed. This pattern is the clue to the area of hospital activity in which a given registered nurse should serve in order to do her best possible job and at the same time find maximum satisfaction for herself.

Hospital management should recognize that there are important differences among the various nursing assignments, and every effort should be made to assign each nurse to the type of duty best suited to her natural inclinations.

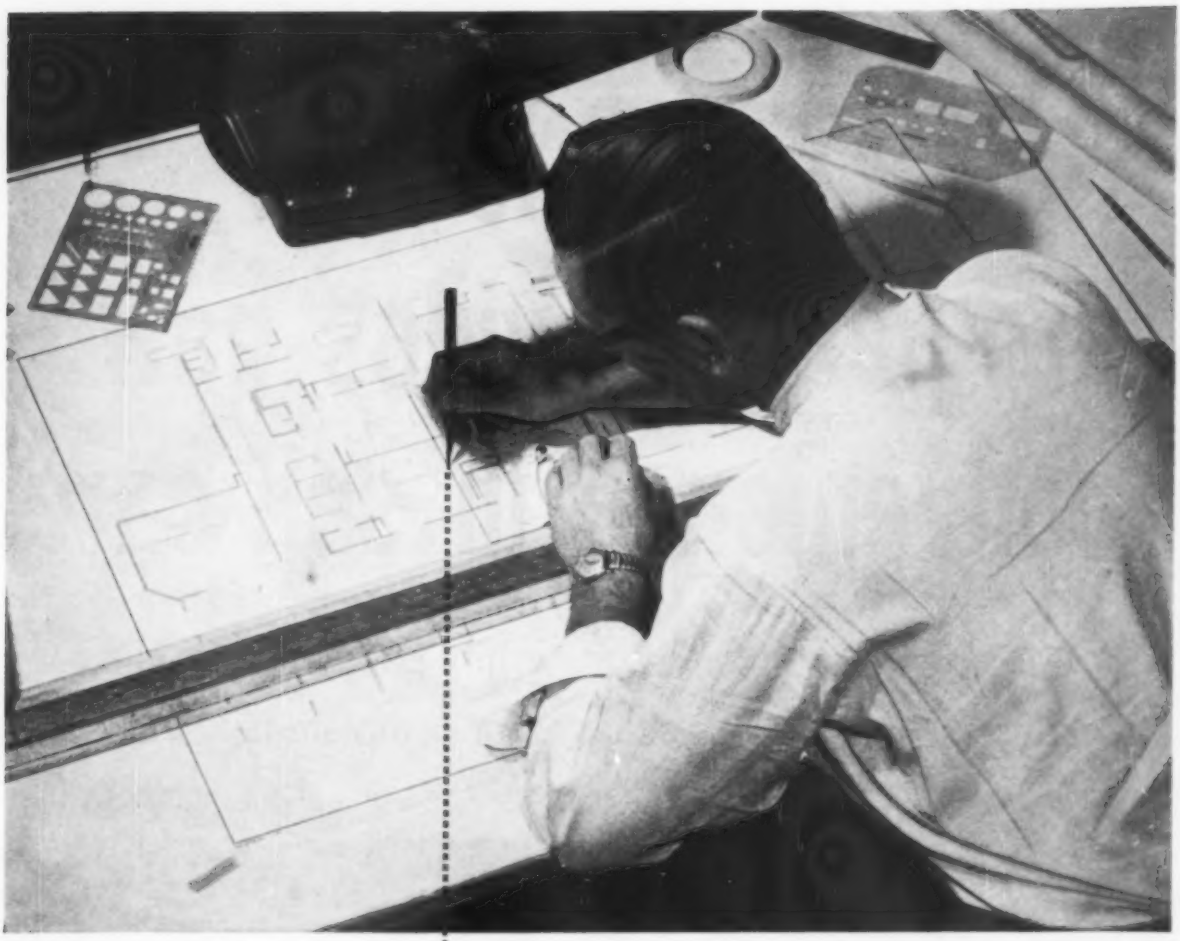
For example, 93 per cent of the nurses in the study reported that they frequently find themselves doing routine and detail work; 86.4 give evidence of having the patience to do such work. And yet only 32 per cent indicate that they enjoy working with figures, compiling data, and maintaining records. Obviously, these 32 per cent should be assigned to duties where their capacity for detail work will be most useful and this, in turn, may free for other duty nurses whose interests are in working more closely with the human element.

Conversely, those nurses who show a genuine liking for being with people, and who are by nature friendly and conversational, would almost certainly become discontented if assigned to the operating room, where the atmosphere is tense, movement is confined, amiability is seldom in evidence, and the patients are silent subjects who are operated on and then removed to a ward. The O.R. nurse seldom if ever has a chance to get to know her patients as human beings. Hospital administrators would be well advised therefore to assign to O.R. duties those nurses whom study has shown to be primarily interested in the technical and physiological, rather than "human" aspects of medicine.

Similarly, the question of "pressure" or nervous strain may be taken into consideration when determining assignments. Our study revealed that 82.3 per cent of the nurses enjoy doing work which offers great variety despite nervous strain; and 54.3 per cent like the stimulus of working under pressure.

It should be noted that the responsibility of the nurse is not restricted to complying with policies established by the hospital management. In keeping with the role of the nurse as an active factor in the growth of the medical profession, 84.3 per cent of the participants in the survey show an inclination to improve on traditional methods of doing things, and 51 per cent have evidence of major changes recommended or initiated by them because they challenged the traditional method of doing things.

In most cases, these changes were in matters of hospital routine and accepted by the hospital administration. But this desire to make contributions to the growth and improvement of medical care extends outside the bounds of the hospital as well. The study revealed that the successful nurse is likely to be an active participant in her local and national nurses' associations; she attends lectures and workshops, and in every way possible manages to stay informed of new trends and technics in nursing. ■



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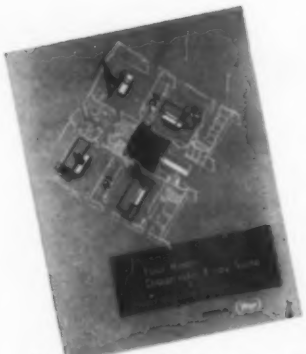

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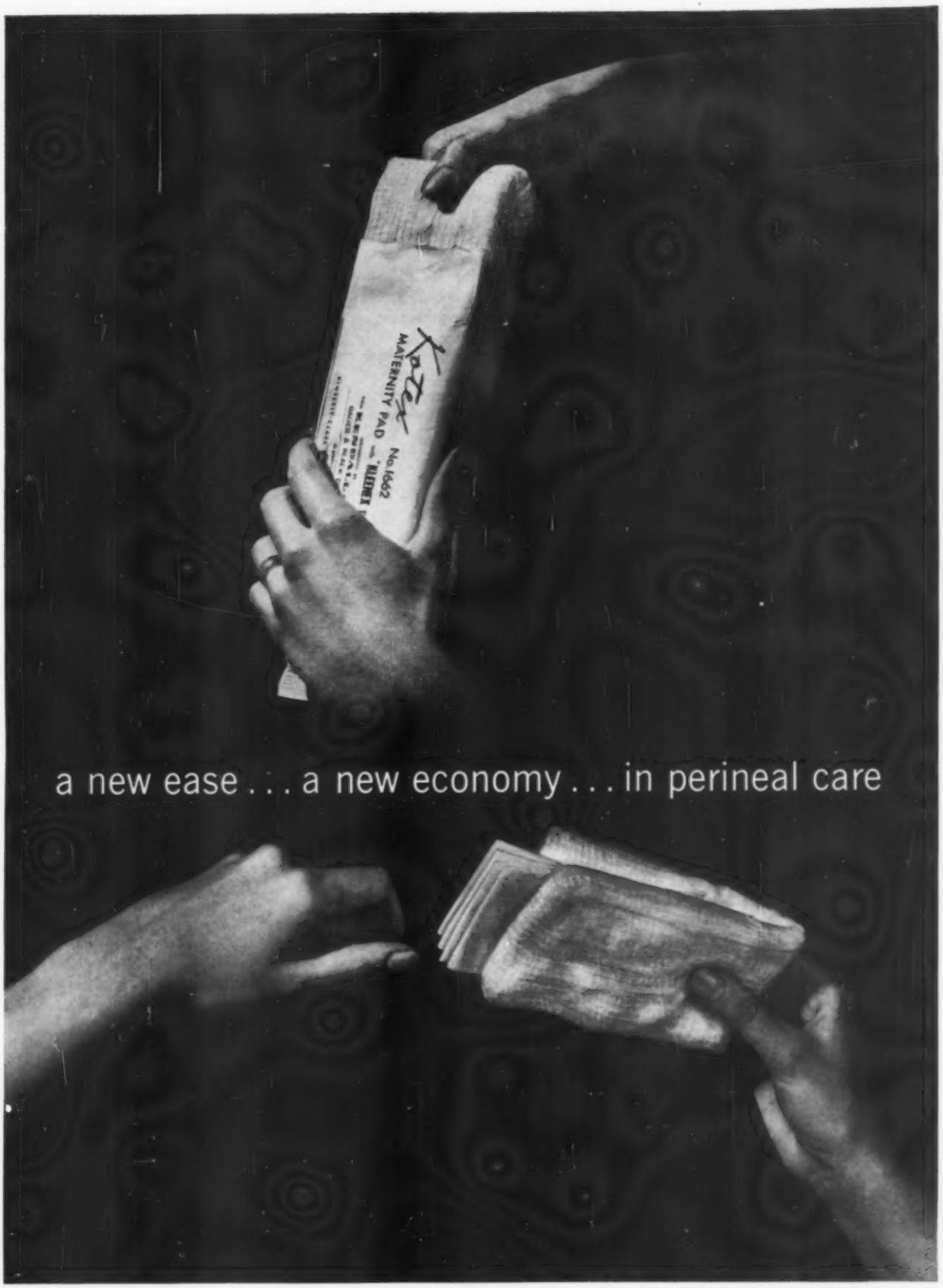


For additional information, use postcard facing Cover 3.

NEWS DIGEST

Two Unions Start Year With Coordinated Drive Seeking Recognition at Ten Chicago Institutions

Chicago. — Two unions, acting in unison, requested recognition from 10 hospitals here late last month.

Local 1657 of the American Federation of State, County and Municipal Employes sent letters requesting recognition to Wesley Memorial Hospital, Columbus Hospital, and Chicago Osteopathic Hospital. (Two other institutions — Mount Sinai Hospital and Chicago Home for Incurables — have been picketed since a strike was called by the Local on Aug. 27, 1959, over the issue of recognition. No acts of violence have been reported on the picket lines, which have been sparsely manned, but windows have been broken at the homes of several nonstriking employes. Officials at both institutions report that the hospitals are operating with a full complement of employes and with no interruption of deliveries by suppliers.)

Victor Gotbaum, district director of Local 1657, said that he had asked for a meeting between hospital and union officials to discuss "wages, hours and conditions of employment" of nonprofessional workers. Mr. Gotbaum said that his letter informed the administrators that "We [the union] stand ready to prove our majority status through an election or in any other manner agreeable to you. Pending the settlement of this matter, we request that the employment of all your nonprofessional employes remain *status quo.*"

Local 743, Warehouse and Mail Order Employes, sent similar letters requesting recognition to the administrators of seven institutions: Mercy Hospital, Illinois Masonic Hospital, Edgewater Hospital, Jackson Park Hospital, American Hospital, Grant Hospital, and Provident Hospital.

Donald Peters, president of Local 743, which is affiliated with the Teamsters union, said that the hospitals had taken the position that there is no law compelling them to recognize unions. On the advice of union lawyers, he said, the Local asked the Chicago office of the National Labor Relations Board to conduct representative elections among nonprofessional employes at the seven hospitals. If we accepted the hospitals' attitude of nonrecognition, he said, "we would have no recourse except to strike, and we are determined to avoid a strike, if possible."

A third union, Local 73 of the General Service Employes Union (an affiliate of the Building Service Employes International) has been active in eight other Chicago hospitals, but has not as yet sought recognition from them. A spokesman for the Local indicated that the union would not seek recognition from any one hospital until it was ready to seek recognition from all eight. "In most of these hospitals," the spokesman told The Modern Hospital, "we have already signed up what we feel to be a majority of workers and we plan to seek recognition from the hospitals early in 1960."

Sister M. Joann, R.N., administrator of St. Elizabeth's Hospital, one of the hospitals at which Local 73 claims to have signed up a majority of workers, said that no organizing activity is presently under way at the hospital, although some leaflets were distributed by the Local to nonprofessional workers, several months ago.

A spokesman for one of the other hospitals at which Local 73 has been active said there are three reasons nonprofit hospitals should not be organized. Such hospitals, he said, have no profits over which to bargain, as they are supported by charitable contributions. Legally, he said, they are specifically exempt from collective bargaining. And perhaps most important of all, he said, "because of the kind of service rendered by hospitals, it just isn't practical to deal with employes through unions."

Breach Between Hospitals and Doctors May Widen, Dr. Crosby Warns I.H.A.

Springfield, Ill. — The breach that has existed between hospital administrators and medical staffs may widen as hospitals grow more complex, Dr. Edwin L. Crosby warned in a talk presented at the annual assembly of the Illinois Hospital Association here last month. Dr. Crosby is director of the American Hospital Association.

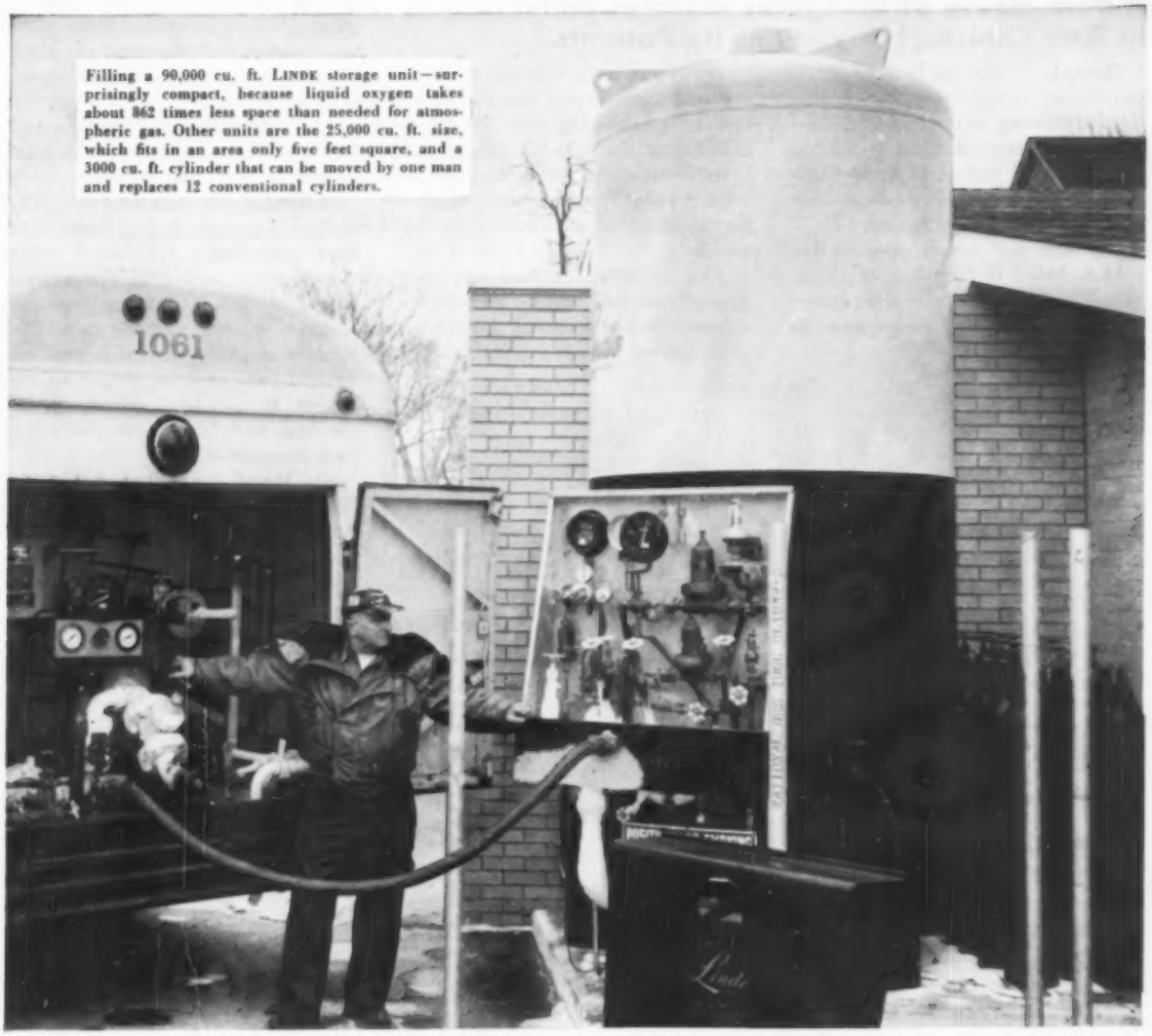
"Misunderstandings between hospital management and the medical profession arise from fears concerning each other," he said, quoting from a 1953 report issued by a joint committee of the boards of trustees of the American Medical Association and A.H.A.

"It is my conviction," he said, "that if these fears are squarely faced by all parties concerned, the issues which block sound and constructive hospital-physician relations will be resolved. They will be resolved because the issues are only symptoms of underlying attitudes."

In a luncheon address, Delbert Price, newly installed president of the I.H.A., said that the state association urged member hospitals to maintain a policy of "nonrecognition" toward labor organizations that seek to organize hospital employes. "We cannot prevent unions from attempting to organize our hospital employes," said Mr. Price, who is administrator of Children's Memorial Hospital, Chicago, "but we must stand firm in our conviction that hospital trustees must not abdicate any part of their responsibility to protect the health and welfare of patients to outside groups that do not have patient service as a primary concern."

George K. Hendrix, administrator, Memorial Hospital, Springfield, was named president-elect of the I.H.A. at the meeting. Norman D. Bailey was named treasurer.

Illinois officers, left to right: Ray E. Brown, retiring president; George K. Hendrix, the president-elect, and Delbert Price, incoming president.



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For additional information, use postcard facing Cover 3.

A.M.A. House of Delegates Restates Belief in Free Choice of Physicians by Patients

DALLAS. — Nervous because many physicians thought newspaper editorials following an American Medical Association action last June permitted the inference that A.M.A. had approved closed panel medical care plans, members of the House of Delegates here last month restated the A.M.A. belief in "freedom of choice of physician and free competition among physicians as prerequisite to optimal medical care."

The House acted in response to several resolutions urging that the earlier report be rescinded. One resolution called upon the A.M.A.'s communications division for an explanation of what it called "gross misinterpretation by a majority of news gathering media."

The communications division promptly replied that no such misinterpretation had occurred, the nation's press having accurately reported last June the A.M.A. policy that "each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care."

To clarify its position, the House of Delegates here made an additional declaration: "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system that provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

The House also reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships With Institutions" (see THE MODERN HOSPITAL, December 1959, page 56) and recommended that the A.M.A. board of trustees should maintain liaison with the board of trustees of the American Hospital Association. Another recommendation acknowledged the need for action by state and county medical societies to strengthen relationships with hospitals.

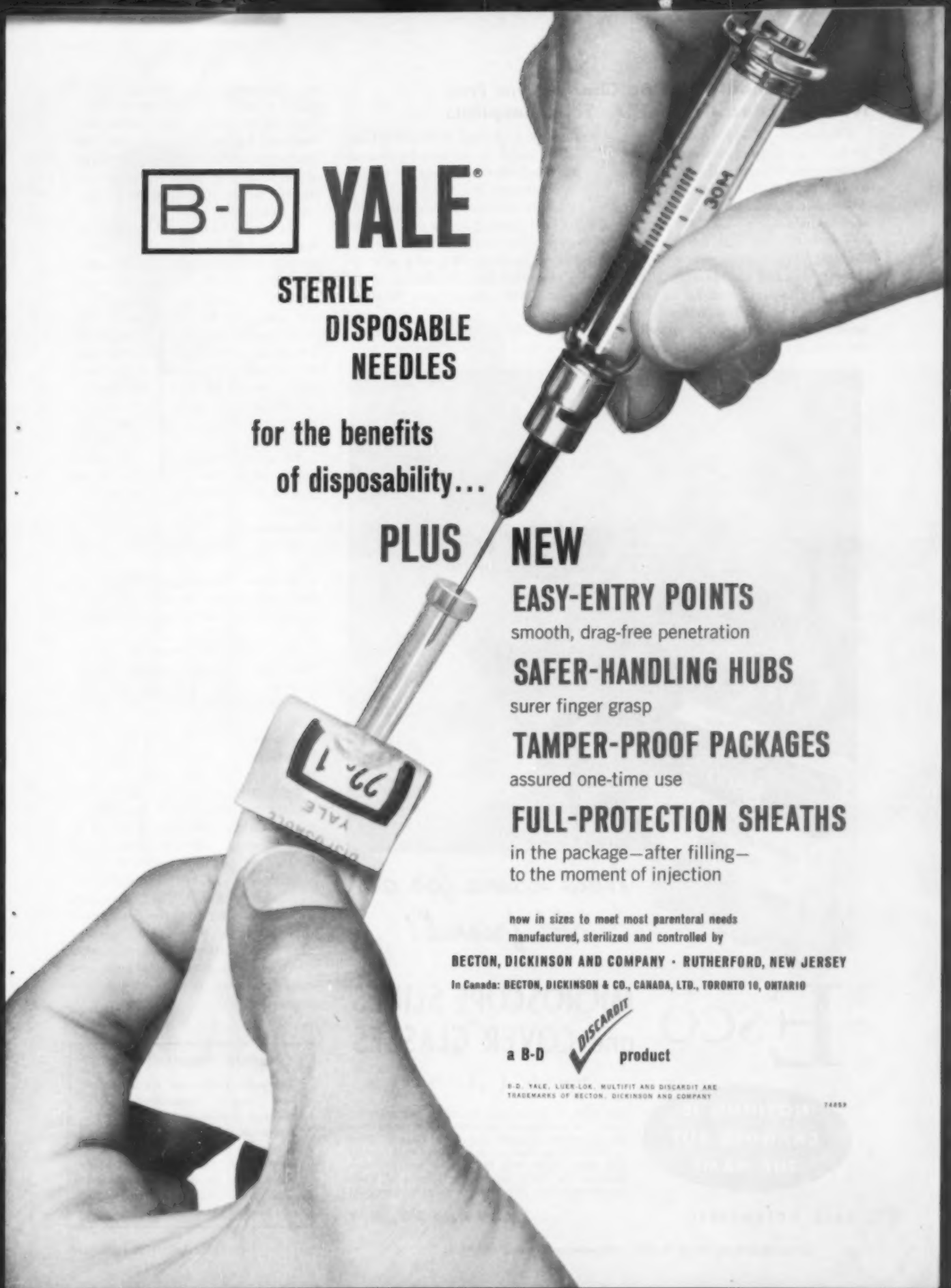
In other actions of interest to hospitals, A.M.A. delegates:

1. Protested failure of Veterans Administration hospitals to screen admission of patients with nonservice-connected disabilities.
2. Directed the Council on Medical Service to submit recommendations on A.M.A. relations with Blue Shield plans and reaffirmed support of the Blue Shield concept.
3. Urged "judicious consideration of local problems" in connection with the June 1, 1960, cut-off date for approval of hospitals accepting interns or residents not certified by the Educational Council for Foreign Medical Graduates.
4. Recommended courses in the social, political and economic aspects of medicine for medical schools.

Maryland Council Elects

BALTIMORE. — John B. Rich, Annapolis, was elected president of the Hospital Council of Maryland, Inc., at its annual meeting here November 24.

Robert S. Hoyt, administrator of Lutheran Hospital, Baltimore, was reelected vice president, and Sister M. Pierre, St. Joseph's Hospital, Baltimore, was reelected treasurer.



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Patients Should Not Be Charged for Free Nursing Education, I.H.A. Tells Hospitals

CHICAGO. — Hospitals should stop giving away nursing education to the students while passing the costs along to the patient, the Illinois Hospital Association's committee on nursing recommends.

Token tuitions that fail to cover the cost of a nursing education, the association said, cause heavy losses that must be paid from the hospitals' general funds. The recommendations related to the shortage of nurses in the state are contained in the second volume of a "School of Nursing Cost Study," based on an investigation of nursing school costs made by a Chicago accounting firm.

Patients in Illinois hospitals with schools of nursing or the third parties who purchase services for these patients are underwriting costs of nursing education in the amount of an estimated $10 million a year, the study discloses.

The study shows that the average gross annual costs of educating a nursing student in an Illinois hospital school is $2620. Of this, only $1000 is defrayed by income from tuition and fees, and by the dollar value of student services during the clinical phases of training. The balance, $1620 per student per year, comes out of hospital funds.

The study findings clear away the fiction that students "earn their keep" through their services on nursing units, the I.H.A. declares. Of the total average cost of educating a student, 49.3 per cent goes for room, board and other maintenance items. Through her service on the floor, the student is defraying only 31 per cent of the total costs. Almost all of the 52 hospital schools included in the study are providing free room and board, the I.H.A. said.

Of special significance, the report points out, is the fact that only 7.2 per cent of the average gross cost of educating a nurse is met by tuition and other fees.

Among recommendations made are:

Increased income from higher tuitions and charges for room and board should be applied to improvements in program.

Hospitals should cooperate with related organizations in a joint civic appeal for nursing scholarships and loan funds for students and faculty education.

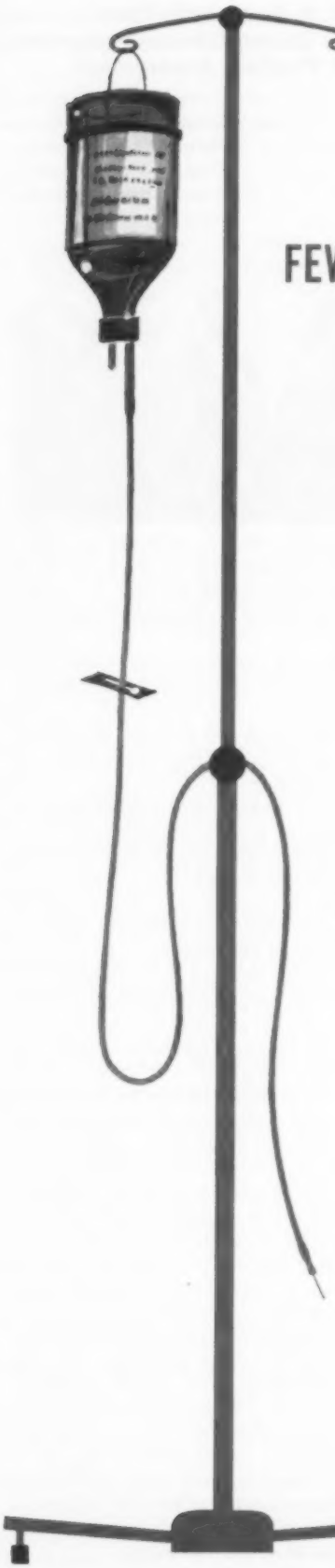
A central referral office should be established to maintain information on scholarship and loan funds.

Schools should explore the use of nonhospital educational facilities in their locality, "purchasing" a part of their students' education from nearby colleges, if this is practical.

Schools should reevaluate their assignments of students to the nursing unit, both to improve the educational experience and to increase the value of student services. Closer consultation between nursing education and nursing service departments is recommended.

Modern Hospital Index

The index to the last six issues of last year's magazines (July through December 1959, Vol. 93) has been printed separately. Send a note or post card for your complimentary copy. Persons who have asked for the previous index will be sent the latest index without further correspondence.



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1. 1958 Report of American Red Cross Joint Blood Council
2. References and detailed literature available on request.

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W. R. Reid Tells Plans for Strengthening Program of Virginia Association

OLD POINT COMFORT, VA. — Plans to build the Virginia Hospital Association into an "architect of hospital management" were outlined by the new president, William R. Reid, Jefferson Hospital, Roanoke, at the annual meeting of the association here in November.

Virginia officers: Winfred C. Bloxom, retiring president; W. R. Reid, president; David Babnew Jr., treasurer; Hunter A. Grumbles, secretary.

He suggested that the association consider the following subjects during the coming year:

1. Promotion and strengthening of regional hospital councils.
2. Consideration of an increase in institutional dues.
3. Expansion of efforts to obtain cost reimbursement for care rendered public agency patients.
4. Recruitment of all health personnel on a considerably expanded scale.
5. Increased emphasis on public relations.

Speaking on labor relations, Maurice J. Norby, deputy director of the American Hospital Association, told the convention, "The adoption of an employe relations program is no longer a privilege of hospital management. It is a requirement. If it does not develop voluntarily — and soon — it will be imposed through an outside organized effort."

George E. Bokinski, administrator of Petersburg General Hospital, Petersburg, was named president-elect. In addition to Mr. Reid, other officers for the coming year are: treasurer, David Babnew Jr., Northampton-Accomack Memorial Hospital, Nassawadox, and secretary, Hunter A. Grumbles, Stonewall Jackson Memorial Hospital, Lexington.

Georgia Inspection Teams To Certify Small Hospitals

ATLANTA. — Hospitals of under 25 beds now have their own program for inspection and certification under a plan recently established by the Georgia Hospital Association and the Medical Association of Georgia.

The inspection program was conceived as a joint device by hospital, medical and trustee groups in Georgia to assist hospitals of less than 25 beds (which generally are not eligible for accreditation by the Joint Commission) in raising their standards of care. The plan will also give recognition to hospitals that meet the program's standards, *Georgia Hospitals* explained in its October issue.

The procedure is to send out inspection teams at the request of the hospitals. The teams submit their findings to a full meeting of the Georgia Hospital-Medical Council and, if minimum standards are met, a certificate is issued with appropriate ceremonies.

An inspection manual has been prepared by the council and uniform checklists to be used by inspection teams will be made available. During 1960 the sponsoring organizations plan to establish and train teams in each district of the state.

Some 35 small hospitals have already requested inspection visits, the council reports.

A similar program is already in operation in Texas. (A report of the Texas plan appeared in The MODERN HOSPITAL in October 1959.)

P.H.S. Transfers Division of International Health

WASHINGTON, D.C. — Policy, planning and staff functions of the Public Health Service's international health program have been transferred to the office of the surgeon general, Leroy E. Burney, surgeon general, announced last month.

These functions were formerly performed in the U.S.P.H.S.'s Bureau of State Services. Dr. H. van Zile Hyde, assistant to the surgeon general for international affairs will be chief of the division. Dr. Horace DeLien, who had served as chief of the division of international health since September 1958, has been assigned to the American embassy in Paris as medical officer in charge of quarantine activities in the European area.

N.L.N.-A.H.A. Committee Appointed To Advise on Nursing Accreditation

NEW YORK. — The National League for Nursing has appointed an advisory committee on accreditation of hospital schools of nursing, with equal representation from the American Hospital Association and the N.L.N., Inez Haynes, the League's general director, announced November 24. The A.H.A. approved the action in August.

The A.H.A. representatives are: Dr. James Z. Appel, Lancaster Pa.; Kenneth E. Knapp, administrator, Thomas D. Dee Memorial Hospital, Ogden, Utah; Sister Marian Catherine, director of nursing and nursing education, St. Vincent's Hospital, New York; Dr. T. Stewart Hamilton, executive director, Hartford Hospital, Hartford, Conn.; Reid T. Holmes, administrator, North Carolina Baptist Hospitals, Winston-Salem; Stewart K. Hummel, administrator, Columbia Hospital, Milwaukee, and Dr. Clark Wescoe, dean of the school of medicine, University of Kansas, Kansas City, Kan.

N.L.N. members are: Henrietta Davis, consultant to schools of nursing, Board of Hospitals and Homes of the Methodist Church, Chicago; Laurene Gilmore, assistant director of nursing education, Birmingham Baptist Hospital, Birmingham, Ala.; Evelyn M. Hamil, director of nursing service and education, Los Angeles County General Hospital, Los Angeles; Hans O. Mauksch, chairman, social science department, Presbyterian-St. Luke's Hospital School of Nursing, Chicago.

Others representing the N.L.N. on the committee are: Ewald B. Nyquist, deputy commissioner of education, state of New York, and chairman, Commission on Institutions of Higher Education, Middle States Association of Colleges and Secondary Schools, Albany, N.Y.; Mildred E. Schwier, director of nursing, Rhode Island Hospital, Providence, and former director of the N.L.N. department of diploma and associate degree programs, and Sister Virginia Kingsbury, consultant to schools in the Western province, Daughters of Charity, Normandy, Mo.

The committee will advise the N.L.N. on means of simplifying procedures and stabilizing financing of the League's accreditation program, as it relates to hospital nursing schools, Miss Haynes said.

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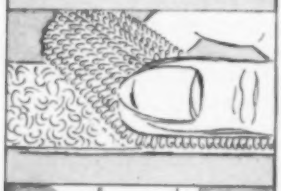

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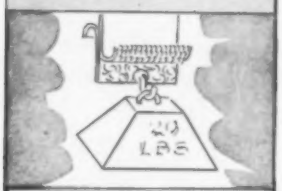
The two Velcro surfaces separate easily when "peeled" from the edge.



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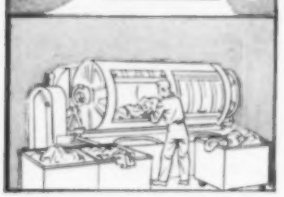

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Internists Approve New Program Designed To Evaluate Nonsurgical Hospital Procedures

CHICAGO. — A program aimed at improving the quality of diagnosis and treatment in hospitals was approved late last year by the American College of Physicians.

Patterned after evaluation programs — such as the medical audit and the group tissue committee — that have been used by surgeons for many years, the program covers all nonsurgical procedures in the hospital.

As in the surgical evaluation programs, the quality of work will be judged by an appraisal committee of staff physicians appointed by the chief of staff.

Dr. Arthur R. Colwell Sr., chairman of the A.C.P. committee that developed the program, said that the committee is not intended to be a policing agency. "Our purpose," he said, "is primarily education. We will call attention to good work as well as to poor work."

Commenting on the work of the committee, which included a four-year study, Dr. Kenneth B. Babcock, director of the Joint Commission on Accreditation of Hospitals, said, "I like their idea. This is another facet by which hospitals can improve their medical care. It is hoped that many hospitals will take advantage of these suggestions."

Dr. George K. Fenn, professor-emeritus at Northwestern University, served as field director of the project, described by him and Dr. Colwell in the October 1959 number of *Annals of Internal Medicine*, which would include a random selection of 20 per cent of a hospital's medical records each month. The records would be carefully appraised, with questions such as these asked by the committee:

Is the history and physical examination adequately presented?

Were blood pressure and weight recorded?

Was there too much or too little laboratory work?

Was the diagnosis justified?

Was there evidence that the physician in charge had a good understanding of the condition?

Were errors or inconsistencies noted, with due respect for legitimate difference of opinion?

Was consultation used when the diagnosis was doubtful or the treatment ineffective?

Was the treatment harmful?

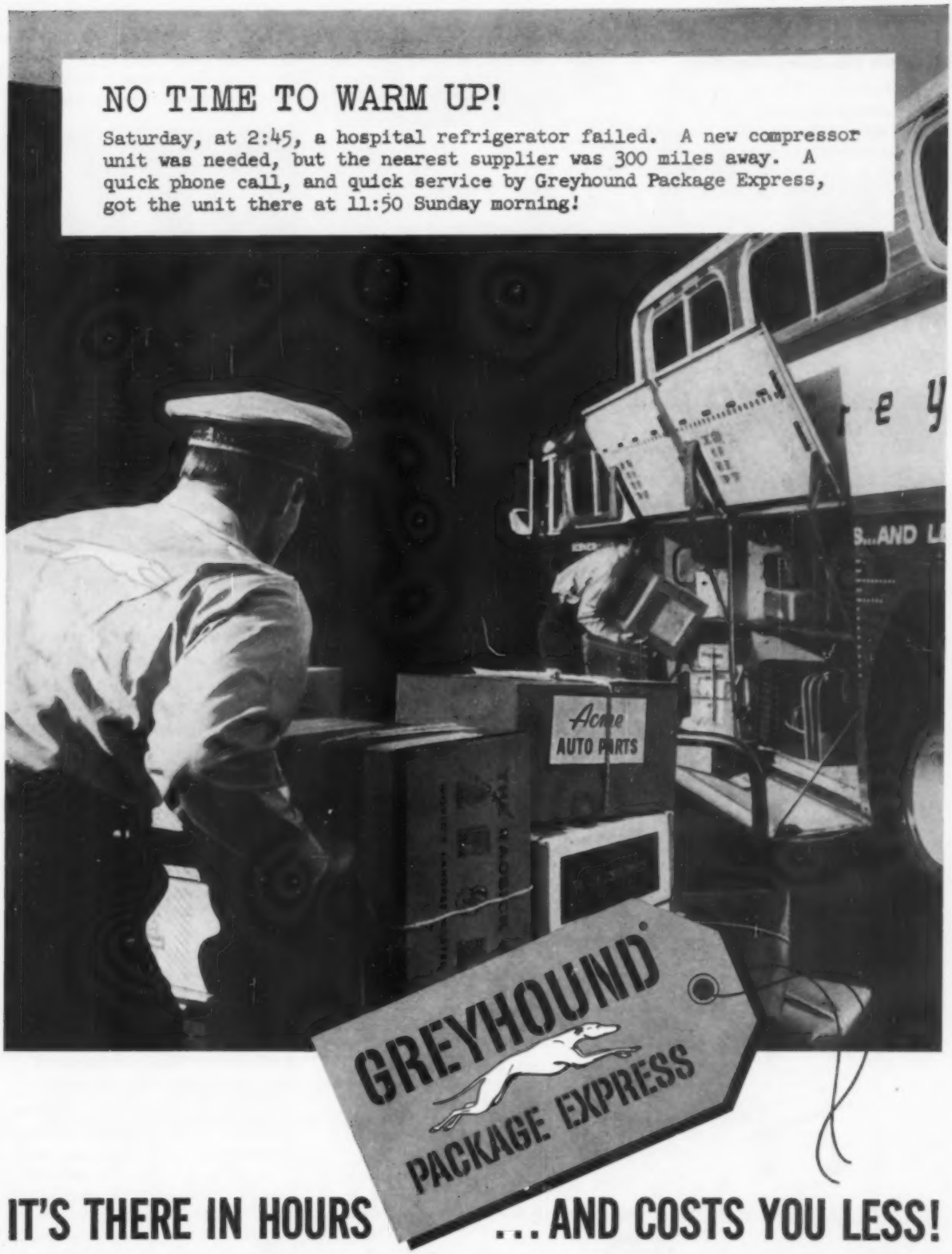
Were avoidable time and expense incurred?

Find 17 Million Persons Limited in Normal Activity

WASHINGTON, D.C. — Chronic conditions affecting health limit the normal activity of an estimated 17 million persons in the United States, according to findings developed from nationwide household interviews conducted in the national health survey of the Public Health Service.

These 17 million persons, representing 10 per cent of the population, are limited in their ability to work, keep house, or pursue outside activities, the survey showed. A segment of this group, amounting to 3 per cent of the population, or an estimated 4,855,000 persons, have trouble moving about or cannot move about without help. Of the latter group, about one million persons are completely confined to their homes, it is reported.

The figures do not include military personnel or persons in mental or other types of long-term institutions.



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Frank Groner Presents Three Challenges to Florida Hospital Meeting

JACKSONVILLE, FLA. — Increasing challenges on the three fronts of care for the aged, preventive medicine, and psychiatric treatment must be met by hospitals in the next 10 years, Frank S. Groner, president-elect of the American Hospital Association, told the Florida Hospital Association during its meeting here December 2 to 4.

Hospital administrators are faced with these specific demands while hospitals are forced to offer additional specialized services to a steadily increasing population, he said.

Mr. Groner told the more than 200 delegates that without close cooperation among hospitals, the increasing demands upon the institutions cannot be met.

At a concurrent meeting with the Florida chapter of the American Association of Hospital Accountants, Ted L. Jacobsen, president of the Florida Hospital Association, asked the two groups to initiate a study of Blue Cross and commercial hospital insurance programs, including catastrophic, in an effort to give better coverage.

Joseph F. McAloon, Hollywood, was named president-elect of the hospital association. Arthur L. Bailey, Orlando, was installed as president for the coming year. Other officers include: secretary-treasurer, I. James Anderson Jr., Vero Beach, and trustees, Robert M. Gantt Jr., Fort Lauderdale, and Sister Mary Clare, Jacksonville.

Three presidents of Florida Hospital Association confer. Left to right: president, Arthur Bailey; president-elect, Joseph F. McAloon, and the outgoing president, Ted Jacobsen.

Roosevelt Hospital Faces Strike Threat in New York

NEW YORK. — Local 1199 of the Retail Drug Employes Union here has called for a strike vote at Roosevelt Hospital.

The Local accuses the hospital of dismissing an employe for union activity, according to an account in *Services Labor Report*.

The hospital's position, as described in the *Report*, is that the dismissal was occasioned by insubordination. The union says the hospital refuses to arbitrate the issue as provided in the statement of policy that ended the union's 46 day strike against a group of New York hospitals, including Roosevelt Hospital, last June.

Executive Housekeepers Plan Biennial Congress

NEW YORK. — Plans for the biennial congress of the National Executive Housekeepers Association were made at a meeting of the national board here in November. The congress will be held in June in San Francisco.

Goals set for the organization include: emphasis on certification for members already in the field, education for persons interested in executive housekeeping, and increased membership.

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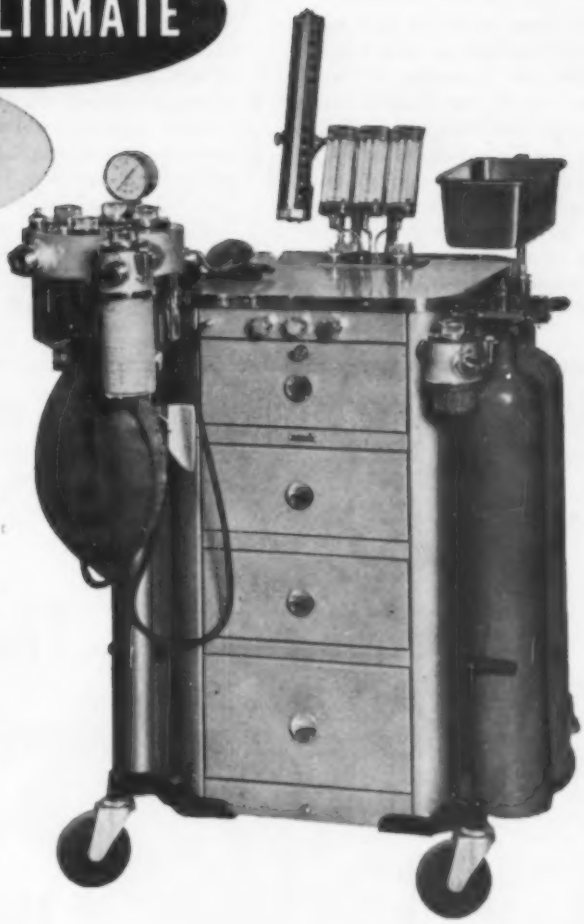

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Half of New York City Interns, Residents Are Graduates of Foreign Schools, Council Finds

NEW YORK. — About half the interns and residents in New York City hospitals are graduates of foreign medical schools, the Hospital Council of Greater New York reported recently. For the United States as a whole, the proportion of foreign-trained house staff is about one-third.

Of the 5200 house staff physicians in approved training programs in New York hospitals, about 2700 have been graduated by medical schools located in the United States or Canada. Of the 2500 who came from foreign medical schools, slightly more than 500 are American citizens who went abroad to study medicine, 400 are foreigners in this country on permanent visas, and nearly 1600 are here on temporary visas, the council found.

The heavy reliance of New York hospitals on foreign-trained interns and residents is a relatively recent development, the council reported. In 1936 they comprised only about 8 per cent of the total.

The report suggests that in the near future there may be a reduction in the number of graduates of foreign medical schools available for service in American hospitals as a result of the recent establishment of the Educational Council for Foreign Medical Graduates. This group examines graduates of foreign medical schools in order that hospitals may have assurance that the interns and residents they employ have a satisfactory command of English and comprehensive knowledge of medicine.

The report pointed out that on the first three examinations given by the council the over-all failure rate was about 30 per cent. "It seems reasonable to assume that the failure rate will not diminish substantially in the near future. How severe the curtailment will be is impossible to predict. A reduction of 30 per cent in the number of foreign-trained interns and residents in New York City hospitals would mean a loss of 700 to 800 men," the report stated.

CHICAGO. — Of the 3068 candidates who took the Educational Council for Foreign Medical Graduates examination in September, the failure rate was approximately 31 per cent, according to figures released recently by the council.

Dr. Dean F. Smiley, executive director of the council, said of the 2351 candidates who took the examination in U.S. centers, 46.3 per cent won standard certificates and 25.6 per cent earned temporary certificates. Of the 717 candidates examined at foreign centers, 39.3 per cent won standard certificates and 19.7 per cent, temporary certificates.

The next examination will be given March 16.

Extend Nursing Program

WASHINGTON, D.C. — The professional nurse traineeship program, originally established under the Health Amendments Act of 1956, has been extended for an additional five years. The traineeships will continue to be available for full-time academic study, but beginning this year a portion of the annual funds will be set aside for nurses enrolled in short-term intensive training courses designed to improve their skills in supervision and administration of nursing services.

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Marsh, A.K., et al.: Pediatrics *24*:404, 1959.

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COMING EVENTS

ALABAMA HOSPITAL ASSOCIATION, Dinkler-Tutwiler Hotel, Birmingham, Jan. 21, 22.

AMERICAN ASSOCIATION OF MEDICAL RECORD LIBRARIANS, Olympia Hotel, Seattle, Oct. 10-13.

AMERICAN HOSPITAL ASSOCIATION, San Francisco, Aug. 29-Sept. 1.

ASSOCIATION OF MEDICAL RECORD CONSULTANTS, Morrison Hotel, Chicago, Jan. 21, 22.

ASSOCIATION OF OPERATING ROOM NURSES, Statler-Hilton Hotel, New York, Feb. 22-26.

ASSOCIATION OF WESTERN HOSPITALS, Statler-Hilton Hotel, Los Angeles, April 25-28.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Roanoke Hotel, Roanoke, Va., April 21, 22.

CATHOLIC HOSPITAL ASSOCIATION, Municipal Auditorium, Milwaukee, May 30-June 2.

GEORGIA HOSPITAL ASSOCIATION, Jekyll Island, Ga., March 31, April 1.

IDAHO HOSPITAL ASSOCIATION, Elk's Lodge, Boise, Oct. 17, 18.

KENTUCKY HOSPITAL ASSOCIATION, Kentucky Hotel, Louisville, March 29-31.

LOUISIANA HOSPITAL ASSOCIATION, Bellemont Motor Hotel, Baton Rouge, Mar. 24-26.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Oct. 12-14.

MASSACHUSETTS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Boston, May 12.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, April 27-29.

MID-WEST HOSPITAL ASSOCIATION, Municipal Auditorium, Kansas City, Mo., April 27-29.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Buena Vista, Biloxi, June 20-22.

NATIONAL ASSOCIATION OF METHODIST HOSPITALS AND HOMES, Columbus, Ohio, Feb. 16-18.

NATIONAL GERIATRICS SOCIETY, Deauville Hotel, Miami Beach, May 8-12.

NEW ENGLAND HOSPITAL ASSEMBLY, Statler-Hilton Hotel, Boston, March 28-30.

OHIO HOSPITAL ASSOCIATION, Veterans Memorial Building, Columbus, April 4-7.

RHODE ISLAND HOSPITAL ASSOCIATION, Sheraton-Biltmore Hotel, Providence, Oct. 4.

SASKATCHEWAN HOSPITAL ASSOCIATION, Beesborough Hotel, Saskatoon, Oct. 12-14.

SOUTHEASTERN HOSPITAL CONFERENCE, Deauville Hotel, Miami Beach, May 3-6.

TENNESSEE HOSPITAL ASSOCIATION, Peabody Hotel, Memphis, May 26, 27.

TEXAS HOSPITAL ASSOCIATION, Memorial Auditorium, Statler Hilton Hotel, Dallas, May 9-12.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, May 2-4.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium, Minneapolis, May 11-13.

WASHINGTON STATE HOSPITAL ASSOCIATION, Monticello Hotel, Longview, March 25.

V.A. Opens Door To Aid Mental Patient's Recovery

WASHINGTON, D.C. – "Open-door" treatment communities are being used by the Veterans Administration in its treatment of mental patients, the agency has announced.

Patients live and work at the hospitals and come and go about the hospital grounds and near-by towns.

Dr. Jesse F. Casey, director of the V.A. psychiatry and neurology service, said the development is in line with the best concepts of psychiatry.

ABOUT PEOPLE

(*Continued From Page 87*)

Herman Jenkins has assumed his duties as administrator of Copper Basin General Hospital, Copperhill, Tenn. He is a graduate of the school of hospital administration of Georgia Business College.

Harold M. Salkind has been appointed administrator of Boulevard Hospital, Long Island City, N.Y.

Dr. Homer F. Ray, acting superintendent of Somerset State Hospital, Somerset, Pa., has resigned to accept a post with the Alaskan State Psychiatric Clinic, Juneau. Dr. Ray was named assistant superintendent of the Somerset hospital in July 1958 and became acting superintendent after the resignation of **Dr. Gerald R. Clark** last summer.

Tedderic Mohr has been named administrator of Highland Sanitarium and Hospital, Fountain Head, Tenn. He succeeds **Elder R. C. Mills.**

William Hiscock has been appointed administrative assistant at Rip Van Winkle Clinic, Hudson, N.Y.

Samuel Davis has been appointed administrator of Hillside Hospital, Glen Oaks, N.Y. He had been administrative assistant, director of outpatient services, Roosevelt Hospital, New York. Mr. Davis is a graduate of the School of Public Health and Administrative Medicine, Columbia University.

E. E. Lowry has retired as business manager of Mississippi State Sanatorium, Magee, after almost 35 years of service.

Sister M. Patricia, S.F.P., has succeeded **Sister M. Bonavita** as administrator of St. Francis Hospital, Jersey City, N.J. Sister Patricia had been administrator of St. Francis Hospital, Bronx, N.Y., since 1953, and previously had been administrator of St. Michael's Hospital, Newark, N.J. Sister Bonavita has succeeded Sister Patricia as administrator of St. Francis Hospital in the Bronx.

Lawrence Robinow has been appointed assistant administrator of Kaiser Foundation Hospital, San Francisco. He is a graduate of the University of California with a master's degree in hospital administration.

Phillip Roth, administrator of Tri-State Memorial Hospital, Clarkston, Wash., since June 1957, has resigned, effective March 1. Previously he had been administrator of Ocean Beach Hospital, Ilwaco, Wash.

Albert G. Wnuk has resigned as assistant administrator of Nassau Hospital, Mineola, N.Y., to become administrator of Highland Hospital, Beacon, N.Y. He is a graduate of the School of Public Health and Administrative Medicine, Columbia University.

David Smith, former administrator of Ennis Municipal Hospital, Ennis, Tex., has accepted a similar position with West Jefferson General Hospital, New Orleans, La.

Richard Steele has assumed his duties as administrator of Utah Permanente Hospital, Dragerton, Utah. He was formerly assistant administrator of Kaiser Foundation Hospital, Vallejo, Calif. Mr. Steele is a graduate of Assumption College and attended the University of Toronto. He served his residency in hospital administration at Veterans Hospital, Oakland, Calif. He is a member of the Medical Entities Management Association of Northern California.

Claude G. Rainey, former administrator of Lakeland Medical Center,

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SURGICAL PRODUCTS NEWS

SAFER SUTURE DISPENSING TECHNIC NOW WIDELY USED IN THE O. R.

Standardization on Davis & Geck Individual Plastic Strip Packs Combines Greater Safety With Simplification of Handling, Shipping and Storage Problems

Old style bulk storage in jars and solutions poses constant threat of cross contamination with "staph." or other organisms, particularly the hepatitis virus whose susceptibility to any cold germicidal solution is unknown. One contaminated suture tube returned to a common storage container may contaminate all the rest. In addition, jars are heavy, hard to open, difficult to store, prone to costly breakage.

New Davis & Geck Surgilope SP® sterile suture strip packs protect each suture individually in sealed plastic double envelopes, completely eliminating the cross-infection hazard of common storage in jars and solutions. Compact, lightweight 3-dozen cartons replace clumsy, fragile jars . . . handling is faster and easier, breakage is eliminated and shipping costs are sharply reduced.

Slippery, hard-to-break suture tubes are awkward to handle and a time-consuming nuisance to open. Razor-sharp edges of broken tubes frequently nick sutures and adhering glass splinters may actually invade the operating field. Unused tubes must be washed, sorted and returned to jars.

With Surgilope SP packaging, the circulating nurse simply strips open the outer envelope to dispense the sterile, sealed inner envelope containing the suture. Three simple, speedy dispensing technics fit any operating room situation. Extra sutures are quickly opened as needed, reducing waste and time-consuming resterilization.

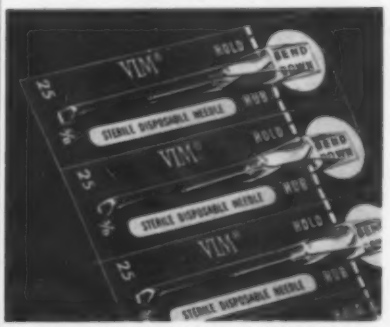
Delivery of sutures, *particularly surgical gut*, on tightly wound reels tends to kink and weaken sutures . . . excessive handling is required for unreeling and straightening.

New Davis & Geck loose-coil winding delivers a supple, kink-free suture, ready for instant use.

INVITES COMPARISON

NEW, SHARPER DISPOSABLE NEEDLE PROVIDES ADDED SAFETY IN ALL-PLASTIC, WET-PROOF PACK

The point of the Vim® Sterile Disposable Needle is the result of extensive research in point design. Penetration tests prove that its 12° top bevel and longer side pointing provide easier tissue entry than the usual more rounded point design. Equally important, this extra sharpness has been achieved without beveling into the lumen, ensuring a stronger point. Unlike weaker lancet-type points, the Vim point will not "fish hook" in penetrating the vial stopper before ever reaching the patient.



The transparent Vim all-plastic wet-proof pack is a truly closed aseptic system, assuring maximum protection against cross-infection. There is no spot-sealed cap to "breathe in" airborne contaminants when subjected to changing temperatures . . . no paper backing easily penetrated by moisture.

The unique Vim plastic hub is square for easier handling, and fused – not glued – to the stainless steel cannula. The needles are ultrasonically cleaned (leave no tattoo marks), and fit any standard Luer syringe.

The Vim Disposable Needle is approved for purchase under the rigid new United States Armed Forces and Veterans Administration specifications for sharpness and package safety. Test it yourself against any other disposable in the field, before placing your next order.

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For additional information, use postcard facing Cover 3.

Muskogee, Okla., has been appointed administrator of the Katy Hospital Employes Hospital Association, with headquarters in Denison, Tex.

Simon C. Spight has been promoted to administrator of Caldwell Memorial Hospital, Baldwyn, Miss. He was formerly a medical technologist.

Sister M. Melchoir has again been named administrator of St. Joseph Hospital, La Grande, Ore. She succeeds **Sister M. Euphrasia,** who has begun duties as administrator of St. Agnes Hospital, Philadelphia. Sister Melchoir spent six years at St. Joseph's, from 1941 to 1947, as administrator before going to St. Joseph Hospital, Tacoma, Wash., where she was in charge of the school of nursing. She was also administrator for nine years at St. Anthony Hospital, Pendleton, Ore.

Gordon Russell has been appointed administrator of Hi Plains Hospital, Hale Center, Tex. He was formerly associated with Hi Plains Clinic, Dimmitt, Tex.

H. Schober Roberts has resigned as administrator of Washington County Hospital, Chatom, Ala., to become administrator of Bryan W. Whitfield Memorial Hospital, Demopolis, Ala. He succeeds **Carl Stapler** who resigned to be administrator of Vaughan Memorial Hospital, now under construction at Selma, Ala.

Robert Trimble has resigned as assistant administrator of Florida Sanitarium and Hospital, Orlando, to be administrator of Ardmore Hospital, Ardmore, Okla.

Dabney Gilliland has resigned as administrator of General Hospital, Greenville, Miss. He has been appointed administrator of John Peter Smith Hospital, Fort Worth, Tex.

E. H. Harris has been appointed administrator of Moton Memorial Hospital, Tulsa, Okla., succeeding **H. G. Hankins,** who resigned to accept a teaching position. Mr. Harris was formerly an auditor for the hospital.

Dr. Cecil G. Baker has resigned as superintendent of Yankton State Hospital, Yankton, S.D. The resignation of **Eldora King** as director of nursing has also been announced by the hospital.

Sister Ann Raymond has succeeded **Sister Catherine Lorraine** as administrator of St. Anthony's Hospital, Las Vegas, Nev. The former administrator has gone to DePaul Hospital, Cheyenne, Wyo., to be in charge of the surgery section. Sister Raymond was formerly administrator of St. John's Hospital, Santa Monica, Calif.; DePaul Hospital, Cheyenne, and St. Vincent's Hospital, Billings, Mont., her most recent assignment.

Department Heads

Kathryn M. Crossland, R.N., has resigned as director of nursing at University Hospital and Hillman Clinic, Birmingham, Ala., to become associate dean of the college of nursing at Texas Women's University, Denton. **Anne M. Howell, R.N.,** associate director of nursing, has been named acting director. **Betty Tomlin** has been named to serve as assistant director of nursing and educational director in charge of expansion of the school and coordination for construction of a new nursing student residence. Mrs. Crossland has served as president of the Alabama State Nurses Association and is a board member of the Health Council of Birmingham and Jefferson County.

Joe N. Cole has been named purchasing agent at Norton Memorial In-

firmary, Louisville, Ky. He attended Pomona College, Tulane University, and the University of Tennessee, training in pharmacy. For 26 years he served in the Army Medical Service Corps, and following retirement was director of administration for the West Virginia department of mental health from September 1957 to June 1959.

Doris Cook has been named assistant administrative dietitian at Barnes Hospital, St. Louis, succeeding **Marian Caddy.** Mrs. Cook is a graduate of the University of Illinois and served her internship in dietetics at Barnes.

Helen L. Guiter, R.N., has resigned as director of nursing service at Aultman Hospital, Canton, Ohio, to become director of nursing at Barberton Citizens Hospital, Barberton, Ohio. Previously she had been assistant chief of nursing service for Veterans Administration Hospital, Downey, Ill. Miss Guiter has bachelor's and master's degrees in nursing from DePaul University, Chicago.

Anne C. Murphy has been appointed chief medical record librarian at Swedish Hospital, Seattle. She was formerly at Washington Hospital Center, Washington, D.C., and Vancouver General Hospital, Vancouver, B.C.

Everett Graff has been appointed controller and **William Pickard** has been named personnel director at Nebraska Methodist Hospital, Omaha. Mr. Graff was formerly with an industrial chemical firm in Washington, D.C., and Mr. Pickard was formerly at Municipal University of Omaha.

George Donnell Axford has been named personnel and employe relations director of Carraway Methodist Hospital, Birmingham, Ala.

E. Frank MacLeod has been appointed personnel director of St. Vincent Hospital and Providence Hospital, Portland, Ore.

Raymond St. Jean has succeeded **John Mullen** as director of purchases and stores at Carney Hospital, Boston.

Ralph L. Drake has been appointed director of the outpatient department at Duke University Hospital, Durham, N.C. Formerly an assistant director of the department, Mr. Drake succeeds **L. R. Jordan,** whose new appointment was announced in the September issue of The MODERN HOSPITAL. Mr. Drake is a graduate of the University of North Carolina.

Miscellaneous

David W. Brumbaugh, vice president and secretary of Time, Inc., has been elected chairman and chief executive officer of Associated Hospital service of New York. Mr. Brumbaugh, a member of the Blue Cross board for 12 years, has been chairman of the administrative committee since the resignation of **Charles Garside** as chairman and president in July.

D. W. Brumbaugh

Louis Block, Dr. P.H., has resigned as chief of the research grants branch, Division of Hospital and Medical Facilities of the U.S. Public Health Service. He is now affiliated with Gordon A. Friesen Associates, hospital consultants, Washington, D.C. Dr. Block had been associated with the Hill-Burton program for the Public Health Service in various capacities.

Louis Block

(*Continued on Page* 156)

Magda Gislaine Pendall, M.D., has resigned as assistant professor of administrative medicine at Columbia University's School of Public Health and Administrative Medicine. She is beginning a 10 month study tour to evaluate the positive and negative factors of postgraduate medical education in the United States, from the point of view of foreign physicians who have had training in this country.

Dr. Magda Pendall

Virginia Ronney has been appointed nursing consultant to the New York City Homestead Studies on public home infirmary care and home medical care. She was formerly director of the rehabilitation nursing program and instructor of nurse education at the New York University School of Education. Previously she spent two years as a public health research fellow for the National Institutes of Health division of research grants.

Lt. Col. Dorothy N. Zeller has been named chief of the air force nurse corps, succeeding **Col. Frances I. Lay,** who has been named command nurse for the U.S.A.F. in Europe. Lt. Col. Zeller is a graduate of the Philadelphia General Hospital School of Nursing and received her bachelor's degree in nursing education from the University of Maryland. She is also a graduate of the hospital administration course at Medical Field Service School, Fort Sam Houston, Tex., and the flight nurse course.

Helen R. Cahill has been appointed director of the dietetic service in the Veterans Administration department of medicine and surgery. She succeeds **Grace Bulman,** who retired in October. Miss Cahill has been assistant director for the last 10 years. She has a bachelor's degree from Iowa State College and a master's degree in personnel administration from George Washington University. Miss Cahill is a member of the American Dietetic Association, the American Home Economics Association, the Association of Military Surgeons, and is currently president of the District of Columbia Dietetic Association.

Deaths

Dr. Ross T. McIntire, former navy surgeon general and White House physician to President Franklin D. Roosevelt, died last month of a heart attack. He was 70 years old. Since 1955 Dr. McIntire had been executive director of the International College of Surgeons in Chicago. He received his medical degree from Willamette University, Salem, Ore., and took postgraduate work at Washington University, St. Louis, and the University of Pennsylvania.

Ogden H. Bowers, onetime administrator of Orange Memorial Hospital, Orange, N.J., died November 28 at the age of 99. At his death, Mr. Bowers was vice president and a trustee of the Hospital Center at Orange, Orange, N.J. In 1958 he was honored for 50 years' service to Orange Memorial, which is affiliated with the center. In 1953 the center named him its "man of the year."

Worth L. Howard, executive director of Akron City Hospital, Akron, Ohio, since December 1935, died November 16 after an extended illness. He was assistant director of University Hospitals, Cleveland, before going to Akron. Mr. Howard was a past president of the Ohio Hospital Association and a fellow of the American College of Hospital Administrators.

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4. **An evaluation of potential volunteer committee personnel for the project.**
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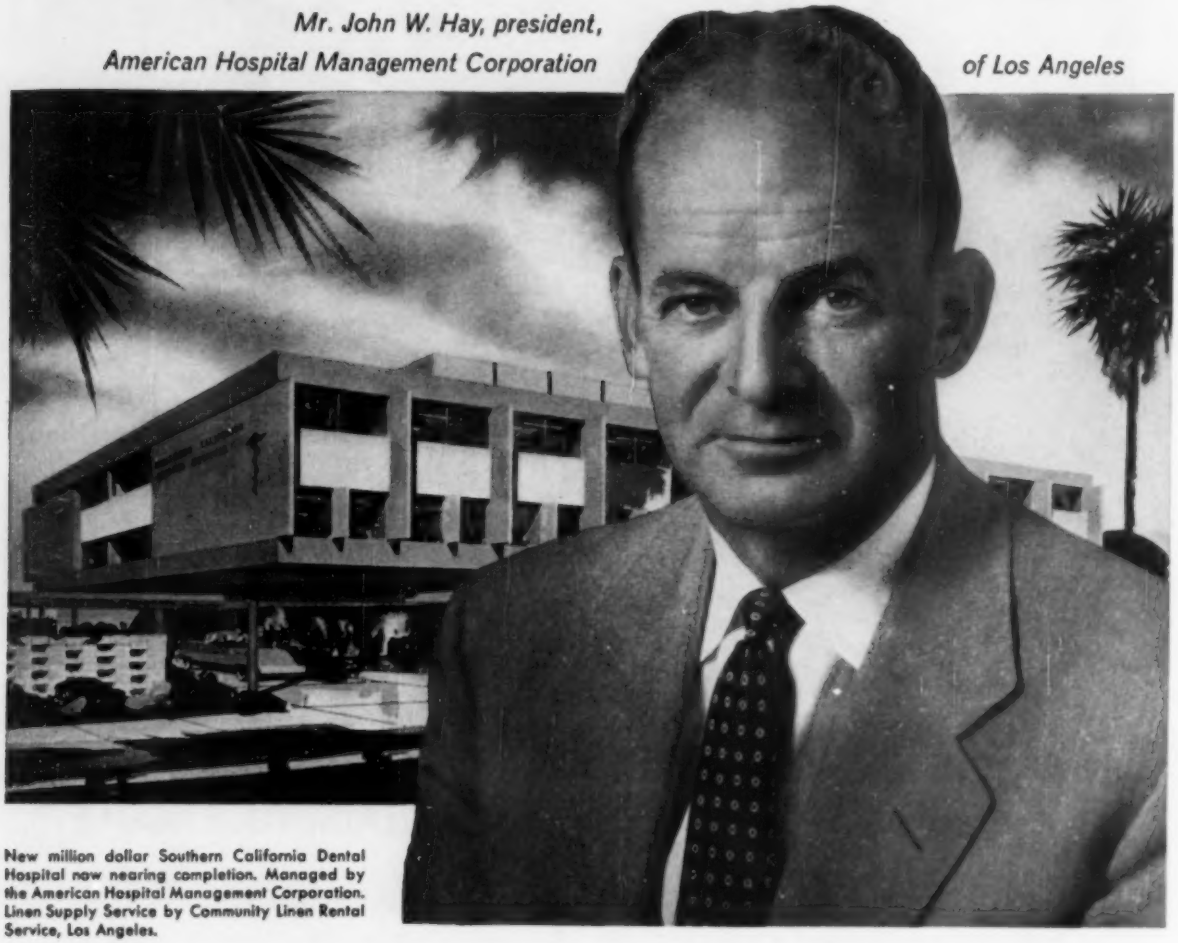

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"We have always recommended Linen Supply Service for the more than 50 hospitals where we have acted in a management or consultant capacity, and we will continue to do so. Our experience has consistently shown that the small cost involved is well worth the advantage of not having to maintain a linen inventory *which usually must be replaced every year*. Linen Supply also eliminates the many maintenance and personnel problems associated with hospital laundries." ▪ Washable cotton uniforms, gowns, sheets . . . everything your hospital needs, supplied where and when you need it. Monies tied up in linen inventory and hospital equipment is freed for other uses. These are just a few of the benefits available to you through your local linen supplier. He is a specialist in service, and in the hygienic laundering of linens for hospitals. Find out how he can solve your many linen problems. Call your local linen supplier, today.

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Note: No investment, no maintenance, no inventory. Everything is furnished and serviced by your local linen supplier, at low cost.

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POSITIONS WANTED

MEDICAL ADMINISTRATOR—10 years, private pract, surgery; many years, teaching experience; former chairman, medical organization; thoroughly familiar, intern & resident training program problems; prefers county-type hospital, 400-beds up w/attending staff, intern & resident program, opportunity do some clinical surgery; late 40's; highly recommended; any locality.

ADMINISTRATOR—5 years, director, 700-bed teaching hospital; any locality; FACHA.

ADMINISTRATOR—8 years, personnel director; acting director, & director, same large, voluntary general hospital—during which time hospital expanded to 350-beds; highly regarded in hospital field; seeks hospital preferable with teaching connections, 250-beds & up; age 38; Member ACHA.

ASSISTANT ADMINISTRATOR—2 years, assistant administrator, 250-bed hospital; 4 years, administrator, small hospital; seeks assistantship, very large hospital or Administrator, hospitals 150-beds up; early 30's; MACHA.

PATHOLOGIST—Diplomate, both branches; M.S., Pathology; 9 years, Director of Laboratory, 300-bed hospital; numerous publications.

PATHOLOGIST—Graduate, St. Louis University, School of Medicine; AOA; trained university hospital; 3 years, instructor, medical school & its graduate hospital; 8 years, divided as pathologist, Chief, associate director, 400-bed hospital, USAF & department, cytology, important medical center; has carried, past 3 years, ½ of teaching & medical school hospital service; duties too strenuous; now seeks preferably pathology in teaching hospital or where residency program exists or can be developed; Certified, Anatomy, taking clinical Boards this Spring; available Feb '60; late 30's; known to us and highly recommended.

RADIOLOGIST—Certified, diagnostic, therapeutic, & isotopes; 3 years, diagnostic & therapeutic radiology, 600 & 700 bed hospitals; 2½ years, associate radiologist, 650-bed hospital; seeks directorship, hospital radiology; prefers Calif., Texas, Mich., consider other localities.

RADIOLOGIST—30; Southerner; graduate Vanderbilt; trained, university hospital & medical school affiliated facilities; completing 2 years service as radiologist, USAF foreign hospital; Board eligible, therapeutic & diagnostic; prefer south, southwest; available July '60.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Day, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR—M.S.H.A. Degree; graduate credits toward Doctorate; 3 years assistant administrator, 175-bed eastern hospital; 2 years administrator, 100-bed hospital; available for appointment.

ASSISTANT ADMINISTRATOR—Age 29; M.S.H.A. Degree, 1958; completed residency, 200-bed eastern hospital; any location considered.

ADMINISTRATOR—Age 48; experience as purchasing agent; past 12 years administrator, 100-bed eastern hospital; available; highly recommended.

COMPTROLLER—Or business manager; age 34 years; 8 years present position; southeast preferred.

ENGINEER—Degree, M.E.; 20 years diversified experience; presently, chief engineer, 500-bed hospital; desires change.

SUPERINTENDENT—R.N.; Age 50; successful administrative experience, 15 years; director, specialized hospital, 4 years; building program completed.

HOUSEKEEPER—4years college; 3 years housekeeper, nurses' residence; assistant housekeeper, 300-bed hospital, Washington, D.C.; east preferred.

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

59678—DENTIST; available after January 1, 1960 when military service terminates; prefers association with group or clinic or employment in institution or industry; also positions allied to dentistry; Certified by Penna. Board of Dental Examiners & National Board of Dental Examiners.

59643—NEUROSURGEON; graduate of University of Freiburg; degree Doctor of Science; published 12 scientific papers; 2 year residency desired.

59684—ADMINISTRATOR; graduate London University, England in Public Administration & Hospital Administration at University of Toronto, Canada.

59689—ADMINISTRATOR; graduate Wharton School of Finance; University of Chicago, Graduate School of Business Administration; Harvard Graduate School of Business Administration; hospital residency in administration; served as teaching associate at Harvard & assistant professor of business administration at University of Georgia.

59634—ADMINISTRATOR or CONTROLLER; graduate Carnegie Institute of Technology & Harvard School of Business; background as assistant administrator and methods engineer.

59641—ADMINISTRATOR; graduate Pennsylvania State University; B.S. Psychology & Business Administration; excellent background in personnel and public relations.

A & G MEDICAL—*Continued*

59611—ADMINISTRATOR or ASSISTANT ADMINISTRATOR—depending size hospital; graduate Florida State University; B.S. Psychology; military service completed; excellent background with AF Hospital.

59652—PURCHASING AGENT; graduate Amherst College; background as purchasing agent for large professional equipment company and pharmaceuticals.

596-101—DIRECTOR OF PUBLIC RELATIONS; graduate of University of Kansas; experience & extensive background in newspaper, radio and TV.

POSITIONS OPEN

ANESTHETIST—Opening for anesthetist available now; 200-bed general hospital located on the near northwest side of Chicago; permanent full time positions. For details write to Executive Director, Lutheran Deaconess Hospital, 1138 N. Leavitt Street, Chicago 22, Illinois.

ANESTHETIST—Nurse; for 220-bed community hospital; working with private group; two full time M.D.'s, four nurses, all agents and techniques; modernization program going on; two and one-half hours from Boston and New York. Write G. J. Carroll, M.D., William W. Backus Hospital, Norwich, Conn.

ANESTHETISTS—Nurse; to cover surgery and OB in 275-bed hospital with A.A.N.A. approved school; work a 40 hour week with time and one-half for overtime; excellent facilities and personnel policies; salary open; call or write Personnel Director, 810 East 27 Street, Minneapolis 7, Minnesota. Phone FE. 2-7266.

ANESTHETIST—Nurse; 30-bed general hospital, southern Minnesota, fringe benefits. Write Springfield Community Hospital, Springfield, Minnesota.

ANESTHETIST—Nurse; new and modern surgery, unusually strong and well diversified surgical staff; good opportunity in new 260-bed expanding hospital, college town location; good personnel policies, 40 hour week, 7 holidays, hospitalization, social security. Apply F. J. O'Brien, Administrator, Chambersburg Hospital, Chambersburg, Pennsylvania.

ANESTHETIST—Must be graduate of Accredited School and adept at all types of inhalation and intravenous anesthesia; 170-bed Accredited Central Pennsylvania Hospital; liberal personnel policies. Contact Mr. Richard E. Cummings, Administrator, J. C. Blair Memorial Hospital, Huntingdon, Pennsylvania.

ANESTHETIST—Nurse; for 25-bed hospital; moving into new hospital about May 15, 1960; salary open, fringe benefits of holidays, sick leave, and vacation. Write Mr. Leonard Ferris, Administrator, Port Allegany Community Hospital, Port Allegany, Pennsylvania.

ANESTHETIST—Nurse; female; accredited modern 250-bed hospital; all new surgery wing; department directed by anesthesiologist; starting wage $500 plus liberal annual increase, three weeks vacation, health insurance, sick leave, retirement plan; American Board surgeons. Apply to Elmer J. Berg, Business Manager, Gundersen Clinic, 1836 South Avenue, La Crosse, Wisconsin.

ASSISTANT ADMINISTRATOR—Eastern teaching hospital over 400-beds; experienced male. Send resume to MO 299, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

DIETITIAN—100-bed, 26 bassinet, general, acute, non-teaching hospital; prefer A.D.A. member but any graduate will be considered; salary open, many employee benefits. Apply MO 254, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

(Continued on page 160)

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POSITIONS OPEN

DIETITIAN—Therapeutic; large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at $300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

DIETITIAN—A.D.A.; faculty position with nationally accredited school of nursing; must be fully qualified; opportunity for individual with initiative and ability to develop and refine program. Contact Director of Nursing, Sewickley Valley Hospital, Sewickley, Pennsylvania.

DIETITIANS—Staff; 2; Capitol City's largest and newest hospital; 290-adult beds; opened 1951; centralized food service, selective menu, ADA preferred, no teaching required; $4,000 starting salary range; liberal personnel policies. Apply Director of Dietetics, Charleston Memorial Hospital, 3200 Noyes Avenue, Charleston 4, West Virginia.

DIETITIAN—Therapeutic; ADA, faculty position in 3 year diploma school of nursing, qualified to teach and integrate dietary program, J.C.A.H. 427-bed general hospital, 40 hour week, liberal personnel policies, salary open. Apply Director of Education, San Jose Hospital, San Jose, California.

DIETITIAN—Position being created by opening of 120-bed rehabilitation addition to Iowa Methodist Hospital; excellent opportunity for ADA registered hospital trained person; possibility of work in either therapeutic or administrative areas; good pay, liberal benefits. Apply Personnel Director, Iowa Methodist Hospital, Des Moines 14, Iowa.

DIETITIAN — Excellent opportunity for ADA registered hospital trained person to direct dietary program in 101-bed JCAH accredited general hospital; dietary department is new with centralized food service; $5,000 starting salary range, liberal personnel benefits. Please contact Mr. Edward C. Ackerman, Director, Fox Memorial Hospital, Oneonta, New York.

DIETITIANS—Staff or therapeutic; ADA approved; needed at once; approved, private, non-profit, 604-bed general hospital; good employee benefits; laundry service and meals; salary open. Apply to Miss Jo Ann Brown, Personnel Director, Akron City Hospital, 525 E. Market Street, Akron, Ohio.

DIETITIAN—Administrative; BS Degree in Dietetics; membership ADA; administrative experience required; good working conditions, liberal personnel policies; Write Personnel Office, The Queen's Hospital, P. O. Box 861, Honolulu, Hawaii.

DIETITIAN—A.D.A. member or eligible with experience in dietary department administration, to direct the dietary service of 125-bed general hospital and train food service employees; entrance salary: $5040 per an-

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POSITIONS OPEN

num; forty hour week; liberal vacation, holiday, and sick leave, social security and retirement benefits; consultant services available from nutritionists, Health Department. Contact Administrator, Knud Hansen Memorial Hospital, St. Thomas, V.I. U. S. A.

DIRECTOR OF NURSING SERVICE—Present director retiring; well organized department of nursing, enjoys excellent rapport with other departments; J.C.A.H. approved hospital, 289 adult beds, modern plant and equipment; located in picturesque Kanawha Valley; no school of nursing at present; prefer candidate with Master's degree and some experience either as director or assistant; progressive attitude on salary, 3 weeks paid vacation, sick leave accumulative to 30 full and 60 half days; truly a desirable position. Apply MO 293, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING, SERVICE AND EDUCATION—With assistant in each area; 3 year diploma program with college affiliation; 338-bed J.C.A.H. accredited general hospital, expanding to 500-beds in 1961; excellent personnel practices; liberal starting salary. Apply MO 295, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

DIRECTOR OF NURSING SERVICE — Direct nursing service in new county hospital, 800-beds; approved residency and intern programs; generous fringe benefits, snowfree winters and low humidity summers; salary $7,140 to $8,916; requires college degree in nursing or nursing administration, five years supervisory nursing experience and eligibility for California RN. Contact Edward W. Firby, Director of Personnel, Room 101, Hall of Records, Fresno 21, California.

DIRECTOR OF NURSING SERVICE—118-bed JCAH accredited hospital, located in attractive college town on the Ohio River; expansion and modernization program underway; salary open. Apply Director, Marietta Memorial Hospital, Marietta, Ohio.

DIRECTOR OF NURSING—Master's degree in Administration desired; applicant with experience preferred; full responsibility for coordinating the educational program and nursing services; an associate director employed for both program; 156-bed general hospital; 72 students in the school; salary commensurate with qualifications. Contact Administrator, St. Margaret Memorial Hospital, Pittsburgh, Pennsylvania. Telephone Mayflower 1-3100.

DIRECTOR OF NURSING — Direct and coordinate work of nursing service and school of nursing; JCAH accredited 302-bed nonprofit general hospital in southeastern Virginia, 25 miles from capital; beautiful hospital and well-equipped diploma school of nursing, with over 100 students; Master's degree essential; salary excellent, commensurate with background and experience. Apply Administrator, Petersburg General Hospital, Petersburgh, Va.

ASSISTANT DIRECTOR, NURSING SERVICE—300-bed JCAH accredited hospital including 34 bassinets; NLN fully accredited school, 100 students; affiliate stu-

(Continued on page 162)

classified advertising

POSITIONS OPEN

dents from Practical Nurse School; B.S. required; experience in in-service educational program desirable. Apply MO 297, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

ASSISTANT DIRECTOR OF NURSING SERVICE—210-bed, general, non-profit hospital with obstetric, emergency and clinic service, 20 minutes from Times Square, New York City; new wing to be erected by 1962; prefer candidate with preparation and/or experience in nursing service administration and in-service education; salary based on qualifications. Apply MO 301, The Modern Hospital 919 N. Michigan Avenue, Chicago 11, Ill.

ASSISTANT DIRECTOR OF NURSING EDUCATION—Master's degree required; some experience desirable; starting salary $6000 per year; liberal personnel policies; 180-bed hospital; diploma school, one class admitted yearly. Apply, Director of Nursing, St. Luke's Hospital, Marquette, Michigan.

EDUCATIONAL DIRECTOR — December 1st or earlier, for accredited school of nursing; 270-beds modern, accredited general hospital and teaching institution for interns, residents, x-ray and laboratory technicians; school affiliated with Oberlin College and Metropolitan City Hospital for specialties; progressive community near universities; excellent personnel policies; salary commensurate with degree and experience. Write Director of Nursing, Elyria Memorial Hospital, Elyria, Ohio.

INSTRUCTORS—Clinical; Medical-surgical, operating room, obstetric nursing, 250-bed JCAH accredited hospital; high caliber students; enrollment 120; affiliation with Grand View College; liberal personnel policies including retirement; friendly, democratic atmosphere; opportunity for initiative and personal advancement; minimum B.S. degree; salary open. Apply Director of Nursing, Iowa Lutheran Hospital, Des Moines, Iowa.

INSTRUCTOR—Clinical; obstetric nursing; 225-bed hospital, J.C.A.H. accredited hospital; N.L.N. provisionally accredited school of nursing; 100 students; post graduate course or B.S. degree and teaching experience required; liberal personnel policies. Apply to Director of Nursing Education, Allen Memorial Hospital, Waterloo, Iowa.

INSTRUCTORS — Medical-surgical; fundamentals of nursing; and medical-surgical specialties; 225-bed hospital; N.L.N. provisionally accredited school of nursing, 100 students; B.S. and teaching experience desirable; liberal personnel policies; minimum salary for qualified person $400 per month. Apply to Director of Nursing Education, Allen Memorial Hospital, Waterloo, Iowa.

INSTRUCTOR—Clinical; in medical nursing; and one in surgical nursing; Bachelor's degree in Nursing or in Nursing Education required; teaching experience desirable; starting salary $5400 per year; liberal personnel policies; 180-bed hospital; diploma school, one class admitted yearly. Apply Director of Nursing, St. Luke's Hospital, Marquette, Michigan.

(Continued on page 164)

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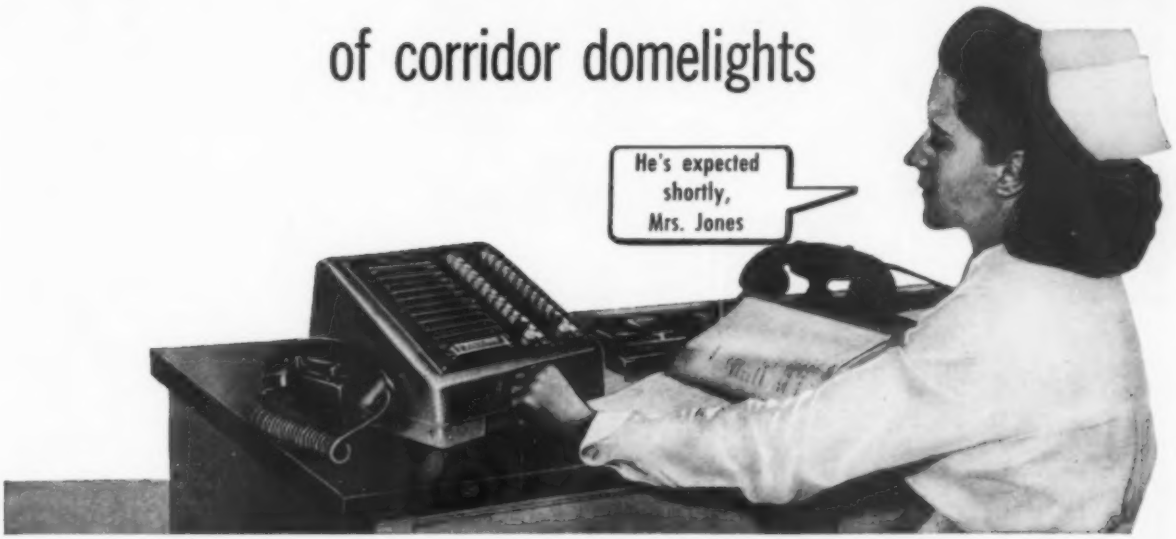
VISUAL nurse call system

of corridor domelights



Executone's DEPENDABLE Audio-Visual Nurse Call System Cuts Foot Travel in Half!

Easily and quickly added to your present visual domelight system, Executone frequently uses *existing* conduits or raceways--providing you with a *modern* Audio-Visual Nurse Call System! All accomplished with no interruption of service during installation!

Many hospitals—old and new—are discovering the economy and efficiency of Executone's Audio-Visual system. More patients are handled with *less effort, in less time!* One hospital reports that Executone has reduced operating costs 8% per bed. *It is an invaluable aid in relieving the nurse shortage.*

By pressing a bedside button, the patient activates signals at three locations—chime and light on nurse's control station, corridor domelight, buzzer and light on duty stations. The nurse presses key to reply . . . Executone's Call System may be installed complete, added to existing domelight systems, or installed without domelights.

Just off the press!

"Better Patient Care"

How Executone communications help hospitals improve patient care and make maximum use of nursing time and skills. Includes a summary of time and motion studies of Executone Audio-Visual Nurse Call Systems made by the Surgeon Generals' offices of the Army and Air Force. Also described and illustrated are Doctors' Paging Systems, Bedside Radio-Sound Systems, Departmental Administrative Systems. Send in the coupon below for your complimentary copy.

Executone

HOSPITAL COMMUNICATION SYSTEMS

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Without obligation, please send me a complimentary copy of "Better Patient Care."

Name_____ Title_____

Hospital_____

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POSITIONS OPEN

INSTRUCTOR—Medical and surgical; Degree in Nursing or Nursing Education; starting salary $4,800.00; location—Central Pennsylvania, 40 miles west of State University. Write Administrator, Clearfield Hospital, Clearfield, Pennsylvania.

INSTRUCTORS—Medical & Surgical, Clinical, Nursing Arts and Pediatrics; Degree in Nursing or Nursing Education or equivalent in experience and education required; expanding, progressive school of nursing with National accreditation; starting salary $345-400 depending upon qualifications. Contact Director of Nursing, Sewickley Valley Hospital, Sewickley, Pennsylvania.

LIBRARIAN—Chief medical record; an excellent opportunity in a modern and progressive hospital in the midwest; unusually high starting salary and periodic reviews; our extensive benefit program includes three weeks vacation after one year and four weeks after five years. Write MO 300, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

STAFF POSITIONS—All clinical areas including psychiatry, respiratory-rehabilitation center; beginning salary $300 monthly; periodic increases 3 weeks annual vacation; opportunity for college study, bachelor's degree program. Write Head, Department of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

NURSE—Registered; administrative supervisor in operating suite; unusual opportunity in active operating department in large midwestern hospital; 40 hour week, 3 weeks annual vacation, liberal salary, merit increases; experience is essential. Apply MO 298, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

NURSE—Anesthetist; to complete staff of three for 85-adult bed hospital; situated midway on Pennsylvania Turnpike between Pittsburgh and Harrisburg; famous resort area; salary open, liberal personnel policies. Apply Miss M. Valigorsky, C.R.N.A., Memorial Hospital of Bedford County, Everett, Pennsylvania or telephone Collect—Bedford 655.

NURSES—General duty; small but active 21-bed hospital located in a friendly community; liberal personnel policies, 40 hour week; delightful dry climate most of the year. Write to Director of Nursing, St. Joseph Hospital, Clayton, New Mexico.

NURSES—Operating room; for expanding 407-bed general hospital located on the Long Island Sound just 45 minutes from the heart of New York City; starting salary $315 plus 2 meals per tour, semi-annual increases for 3 years; $15 bonus paid for each stand by and call night; paid vacation according to tenure up to 28 days, 8 paid holidays, paid sick time, social security; scholarship aid available for continued collegiate study. Apply Operating Room Supervisor, New Rochelle Hospital, New Rochelle, New York.

(Continued on page 166)

classified advertising

POSITIONS OPEN

NURSES—Registered; 200-bed general hospital, near Boston; graduate study, cultural advantages; live-in, optional. Apply Director of Nursing, Woonsocket Hospital, Woonsocket, Rhode Island.

NURSES—Registered; for 50-bed general hospital; approximately 7,000 population; 48 hour week, 2 weeks paid vacation after one year; sick leave, holidays, liberal personnel policies; nurses residence available; starting salary $325 a month and full maintenance. Write Administrator, Coon Memorial Hospital, Dalhart, Texas.

PHYSICAL THERAPIST—Staff; fully approved 60-bed orthopedic hospital, predominantly crippled children; female with minimum two years experience required; vacation with pay, sick leave, insurance benefits; starting salary $4800, maximum $6300. Apply Administrator, Marmet Hospital, Marmet, West Virginia.

PUBLIC RELATIONS AND FINANCE OFFICER—wanted to solicit funds for endowment and operation of 300-bed general hospital, to promote hospital through church conference, to prepare and publish hospital literature, to work with foundations, industry, etc. on potential gifts; located in the heart of the Blue Grass of Kentucky; 100,000 population; university and colleges; salary open, depending upon qualifications and experience. Write W. S. Murphy, Administrator, Good Samaritan Hospital, Lexington, Kentucky.

SUPERVISOR—Operating room; for 50-bed hospital; J.C.A.H. approved; outstanding personnel policies; good salary. Apply Administrator, Gibson Community Hospital, Gibson City, Illinois.

SUPERVISOR—Operating room; JCAH accredited 350-bed general hospital, with NLN accredited school of nursing; operating room suite is new, modern and completely air conditioned; advance preparation and experience required; excellent personnel policies including group life insurance, Blue Cross, social security, vacation and sick leave benefits; salary open. Write stating age, experience, salary desired to Personnel Director, Bethesda Hospital, Oak St. & Reading Road, Cincinnati 6, Ohio.

SUPERVISORS—Excellent opportunities for qualified nurses, in new 200-bed wing to open with extensive clinic facilities modern equipped; fully approved by Joint Commission; intern-resident program, fully accredited school of nursing; liberal benefit program, 4 weeks vacation. Apply Personnel Director, Christ Hospital, Cincinnati 19, Ohio.

SUPERVISOR—Obstetrical; for 575-bed hospital; presently the obstetrical department has 53-beds; an entirely new obstetrical unit is being placed in the new building, with all the latest improvements including an obstetrical recovery room; no student teaching responsibilities; full time clinical instructor in the department; school has 300 students and has full accreditation by the National League for Nursing; starting salary $3840.00; hospital has liberal personnel policies; four weeks vacation, social security and hospital

(Continued on page 168)

. . . And now the postoperative report–

dictate it quickly, accurately with the Edison Voicewriter!

THE OPERATION IS OVER . . . time for the report. The surgeon has but to pick up a nearby phone . . . one of the dictating stations in the hospital's Edison Voicewriter System. He can dictate his report while details are still fresh. The medical secretary will transcribe directly from the Voicewriter Diamond Disc.

So much easier for him. So much better for your hospital! With an Edison Voicewriter installation, there's no waiting for a secretary to take dictation . . . no time spent writing longhand reports. Your doctors complete any medical record you require with half the effort!

Easier for your secretarial staff too. No more backlog. No more hours consumed taking—and waiting to take doctors' dictation! No problem deciphering written reports either. When secretary transcribes, the dictation comes through loud and clear from the Voicewriter Diamond Disc.

Have this dependable dictating facility wherever records originate: in the surgical suite, doctors' offices, nurses' stations, clinic, pathology and radiology rooms. That's how to get the complete, up-to-the-minute medical records a good hospital must have.

No time wasted when doctors dictate their reports with a Voicewriter—the finest dictating instrument ever built

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POSITIONS OPEN

retirement plan; attractive living accommodations available; each room has its own private bath and shower; city has many cultural advantages; hospital in a beautiful 40 acres park; qualifications—B.S. Degree, past experience and preparation in obstetrical nursing. Apply to Director of Nurses, The Reading Hospital, Reading, Pennsylvania.

SUPERVISOR—Operating room; 240-bed general hospital; active surgical service in modern operating suite; B.S. degree in nursing, or equivalent; satisfactory experience in supervision and management; salary open; 40-hour week, liberal vacation and other fringe benefits. Apply Memorial Hospital, Johnson City, Tenn.

SUPERVISOR—Obstetrical; modern 40-bed hospital 60 miles from Minneapolis-St. Paul; to take care of labor room, delivery room, and nursery; 40 hour week; liberal personnel policies; salary open; position open November 1. Write or telephone Hospital Administrator, Apple River Valley Memorial Hospital, Amery, Wisconsin, Telephone Congress 8-7151.

TECHNICIAN—Xray; for modern 29-bed hospital; medical staff of three doctors. For further details write Jack Freese, Faulk County Memorial Hospital, Faulkton, South Dakota.

TECHNICIAN—ASCP Registered laboratory; wanted by 100-bed hospital; Apply G. N. Wilcox Memorial Hospital, Lihue, Kauai, Hawaii.

The Medical Bureau
M. BURNEICE LARSON—DIRECTOR
Telephone DElaware 7-1030
900 N. MICHIGAN AVENUE, CHICAGO

ADMINISTRATORS—(a) Medical director, internationally renowned medical plan, servicing 60,000; direct 60 physicians, large outpatient clinic, projected hospital; east. (b) Medical director, new out-patient rehabilitation center; develop medical programs; good opportunity semi-retired or retired person; resort area. (c) Director medical education and research outstanding U.S. university affiliated teaching institution; new department; top salary well qualified person. (d) Administrator, 400-bed hospital, medical college affiliation; approved nursing school; $15-20,000; east. (e) Administrator, 70-bed hospital, planned expansion to 110; $12,000, midwest. (f) Assistant Administrator, general hospital, expansion to 400 by 1962; near Chicago; $7-8000. (g) Administrative Assistant; new position 350-bed teaching hospital; east $7000. MH-1

classified advertising

POSITIONS OPEN

MEDICAL BUREAU—*Continued*

ADMINISTRATIVE PERSONNEL — (a) Clinic business manager; direct large medical group, Southern California. (b) Public relations director; building program $12 million 400-beds non-sectarian hospital, midwest. (c) Personnel director 350-bed hospital, New York State; new position; $8000. (d) Food service director, east, $7000 up. MH-2

ANESTHETISTS—(a) Alternate responsibility with another anesthetist, 80-bed hospital; wealthy oil center; Texas; $8500. (b) Anesthetist, also act as director of nurses; 30-bed hospital, southwest ranch area; $9000. (c) OB; 150-bed hospital, Florida resort city $6000; also OR; top salary, plus call. (d) Charge of anesthetist service, small rural hospital near Cincinnati; excellent financial arrangement. (e) Anesthetist act as administrator new 18 bed hospital, California. MH-3

DIETITIANS—(a) Chief; 150-bed hospital, N.Y.; $6500 up. (b) Dietitian, 50-bed hospital, Texas $5000; need not be A.D.A. MH-4

DIRECTOR OF NURSES—(a) Strong administrative ability for nursing service, 500-bed hospital ideal California location; to $12,000. (b) Director nursing service and school; 350-bed hospital; 150 students national accredited school; $7-8000, 3 room apartment. (c) Assistant director nursing service, 300-bed hospital Florida Coast; $5000 up. (d) Direct nursing service, small school, Turkey; modern hospital paid air travel. MH-5

EXECUTIVE HOUSEKEEPER — 200-bed hospital, commuting distance N.Y.C.; to $6000; MH-6

MEDICAL RECORD LIBRARIANS—(a) Chief, well established department, 250-bed hospital, college town, Florida; $6000 up; (d) Alaska assignment one year; act as records consultant, 80-bed hospital; large military installation; (e) Record librarian, complete responsibility 35-bed new hospital; Maine seacoast town; summer ocean resort; good salary, excellent living conditions. MH-7

Telephone: Randolph 6-5682

ADMINISTRATORS—(a) Replace retiring medical director; outstanding 900-bed hospital; staff of 550 physicians; will act as assistant medical director, short time; midwest. (b) Superintendent; 60 acute, 100-chronic beds; JCAH; 60 miles from Chicago. (d) New general hospital; $18,000; many excellent fringe benefits; not too far from San Francisco, Calif. (e) Director, professional services, 450-bed hospital; 50 residents; 20 interns; medical school affiliated, $1700-$2100; midwest. (f) General, JCAH, 100-beds; $12,000; midwest. (g) Executive director; State hospital

(Continued on page 170)

classified advertising

POSITIONS OPEN

WOODWARD—Continued

association; $12-15,000. (h) 100-beds voluntary, general, JCAH; very cooperative Board; $12,000; Maine. (i) 100-bed, voluntary, general, JCAH hospital; Ohio. (j) Business manager; clinic group established '46; 33 Board or eligible men representing all specialties; also operate 4 branch offices; New York State. (k) Assistant; female only, w/MHA; general hospital increasing to 250-beds; salary negotiable; no maintenance; lovely residential town 20,000, near metropolis; east. (l) Assistant; under 40; fully-approved, 250-bed, voluntary, general hospital; excellent Board; college town 60,000; northwest. (m) Assistant; prefer minimum 5 years experience w/MS hospital administration; JCAH, voluntary, general hospital expanding to 500-beds; college town 100,000; southwest.

ADMINISTRATIVE POSTS — (n) Full charge admitting office & discharges; 3 hospitals, comprising, university medical center; supervise department of 30; about $5,000; mideast. (o) Personnel director; male or female; university hospital, large size; east. (p) Purchasing Agent; 400-bed, fully-approved, general hospital; large town, 70,000; midwest.

DIRECTOR OF NURSES—(q) Requires qualified nurse administrator able secure national accreditation for school, coordinate school, service; M.S.; voluntary, general hospital, 200-beds; to $12,000; eastern university center, (r) Service only, requires M.S.; 300-bed university hospital, potential 450-beds; city 35,000; midwest.

EDUCATIONAL DIRECTORS—(s) Head department of nursing, new program established by southeastern college; coordinate college, hospital facilities; residential community. (t) M.S. required to head approved school, 250-bed, general hospital, expanding soon; $7500 or better; resort area; southwest.

EXECUTIVE HOUSEKEEPERS—(u) Requires reorganizational ability; hospital expanding to nearly 500-beds by 1961; $5400; large eastern university city. (v) Establish department, new 150-bed, general hospital opening early 1960; residential suburb lovely southern university center.

NURSE ANESTHETISTS — (w) General hospital, 400-beds expanding to 600; $6,000 plus call; Florida resort location; (x) Voluntary, 250-bed hospital; $6800, full maintenance; residential suburb Chicago.

PHARMACIST — (y) Requires California registry, eligibility; 100-bed, general hospital; $8100; ocean community 25,000. (z) Chief; able coordinate pharmacy; 200-bed, general facility; city 60,000; midwest.

INTERSTATE MEDICAL PERSONNEL BUREAU
Miss Elsie Dey, Director
332 Bulkley Building
Cleveland 15, Ohio

ADMINISTRATOR — (a) Small Colorado hospital. (b) 60-bed private hospital, Virginia. (c) 60-bed Michigan hospital. (d) R.N.; 175-bed institution, Illinois; $400, maintenance. (e) 65-bed specialized hospital; south.

ADMINISTRATIVE ASSISTANT — (a) Well-known mid-western hospital; 650-beds. $7,000. (b) 200-bed hospital, Ohio. (c) 150-bed hospital Pennsylvania; accounting background preferred. (d) Large institution, central states; $6,000; open February.

CONTROLLER—(a) 350-bed Ohio hospital. (b) Business manager; 250-bed hospital; New York State. (c) Credit-collection manager; 400-bed southern hospital.

HEAD, PURCHASING DEPARTMENT—Southern hospital.

PERSONNEL DIRECTOR—(a) Outstanding hospital, near Philadelphia. (b) Sisters' Hospitals; midwest.

DIRECTORS, NURSING SERVICE—(a) $7-8,000. (b) Instructors; all specialties; progressive hospitals; excellent locations.

CHIEF RECORD LIBRARIAN—(a) 350-bed eastern hospital; $6,000. (b) West Coast. (c) South; $450.

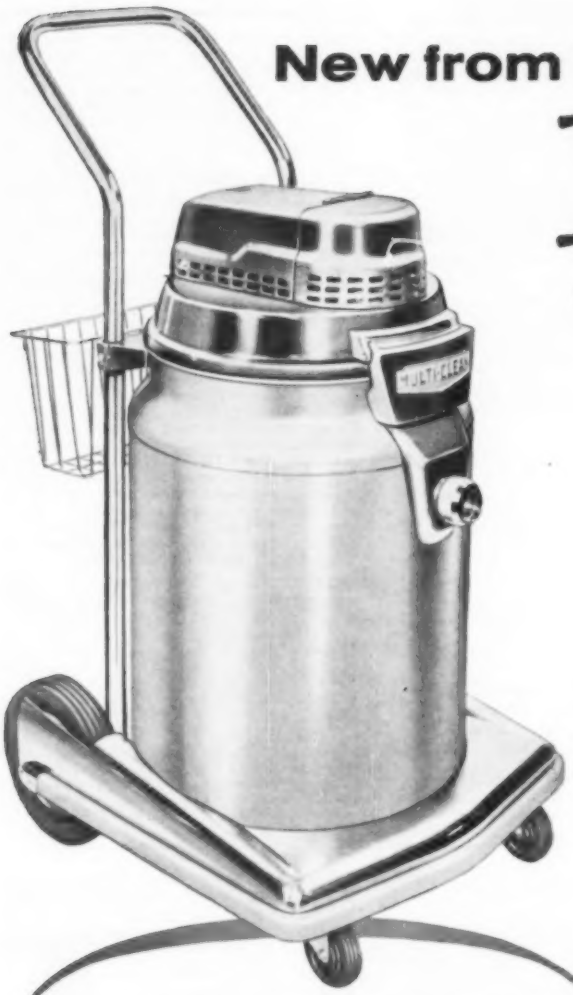
EXECUTIVE HOUSEKEEPERS—(a) To $6,000. (b) Floor maintenance supervisors; $4500.

(Continued on page 172)

New from MULTI-CLEAN . . . the

Imperial

VACUUM CLEANER



It's Powerful! To create the powerful suction needed for *complete pickup*, the heavy-duty turbines of the new Multi-Clean IMPERIAL pull in air at rates up to 216 miles per hour.

By moving *more cubic feet per minute* . . . and *at greater* speeds, more suction is naturally obtained.

It's Rugged! Despite their handsome, elegant styling, the Multi-Clean IMPERIALS have the heavy duty construction needed to make them real work horses. Motors, too, last longer.

This is because power for the IMPERIAL "10" and "15" Series Vacs comes from special heavy-duty motor units designed and built by Multi-Clean exclusively for this purpose. They turn at 12,000 rpm with no load and 9,550 rpm with full load. This is *much slower* than the speed at which most other vacuum motors must operate in order to create the same suction. This slower speed means less wear, longer life.

It's Easier to Operate! The IMPERIAL is designed with the user's convenience in mind.

The tank, for example, has a non-clogging gravity drain. It can be emptied of liquids without disturbing the head. Large gray wheels make it easier to move up and down stairs or from building to building. In addition to the wheels, it also has two ball bearing gray swivel casters. This makes it virtually tip-proof by providing support at 4 points instead of the usual 3 . . . an important factor when we realize a 17-gallon Vacuum Cleaner weighs about 300 lbs. when full!

More Features! Patented, washable filter is pleated to provide 1400 sq. in. of filter area. It's made from a special quick-drying synthetic fibre that won't rot or mildew. Can be washed, rinsed, and drip-dried in minutes . . . 30-foot, 3-conductor cable has same twist lock connector as most Multi-Clean Floor Machines. If you wish, same cable can be used for both . . . Stabilized motor brushes (an exclusive, patented Multi-Clean feature) outlast standard brushes 2 to 1.

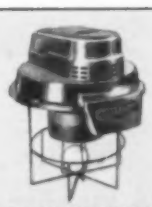
You'll want to learn more about these exciting new Vacuum Cleaners. Call your Multi-Clean Distributor *today* . . . or write to Multi-Clean Products, Inc., Dept. MH-71-10 St. Paul, Minn.

3 Series; 10 Models

The new Multi-Clean IMPERIAL line of Vacuum Cleaners consists of 3 series: the IMPERIAL "5" (½ hp), IMPERIAL "10" (1 hp), and IMPERIAL "15" (1½ hp). Each of these power units may be used with 7, 12, and 17-gallon tanks and with a Kon-Vert-O-Vac attachment on a 55 gallon drum; thus power and tank capacities can be tailored to your needs.

MULTI-CLEAN® *Method*

17 GALLON TANK 12 GALLON TANK 7 GALLON TANK



½, 1, OR 1½ HP POWER HEAD

PATENTED WASHABLE FILTER

STABILIZED MOTOR BRUSHES

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POSITIONS OPEN

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

LIBRARIANS—Medical Record; (a) 250-beds; state of Washington. (b) 169-beds; Calif.

INSTRUCTOR—Surgical nursing; 258-beds; three year professional program; affiliation with university; salary range governed by experience; southwest.

ADMINISTRATOR—Female; salary with full maintenance; west.

UROLOGIST—To locate in community in west.

RADIOLOGIST—Opportunity in Hawaii; immediate placement.

PATHOLOGIST—Hawaii; Certification by APB required.

A & G MEDICAL—*Continued*

DIRECTOR OF NURSING SERVICE AND EDUCATION—Salary commensurate with experience; Va.

DIRECTOR OF EDUCATION; To head and establish School of Practical Nursing; salary $6,000; east.

INSTRUCTOR—Operating room nursing; immediate placement; will consider individual with good experience as instructor and lacks finances to complete education; hospital will consider completing applicant's education at their expense; east.

DIETITIAN—Therapeutic; (a) 235-beds; salary $400 month; southwest. (b) Therapeutic; 300-beds; ADA eligible; salary depends on experience; Pennsylvania.

SUPERVISOR OF NURSES—100-beds; Osteopathic Hospital; Pennsylvania.

PSYCHIATRIST—1700 beds; Mental Hospital; salary to $20,000; hospital will pay travel expenses for interview.

EDUCATIONAL SECRETARY—for Board of Nurse Examiners; Board will pay expense of personal interview.

PEDIATRICIAN—To locate in California due to death of pediatrician 35 years of age; details of office space, practice & hospital staff privileges can be worked out.

SHAY MEDICAL AGENCY
Blanche L. Shay, Director
55 East Washington Street
Chicago 2, Illinois

ADMINISTRATIVE. (a) Finance officer; south; 350-bed hospital; duties: to raise funds both operating and endowment locally among churches, industries, etc., write public relation literature; $8000 minimum plus expenses. (MH-3542) (b) Director of volunteers and public relations; east; 250-bed teaching hospital; be familiar with personnel principles and practices with regard to public relations. (MH-3374) (c) Assistant administrator; east; 118-bed hospital; A 132-bed addition under construction and will be opened early in 1960. (MH3603) (d) Office manager; southwest; 300-bed hospital; newly created position; good background in accounting; some collections experience helpful. (MH-3296) (e) Business manager; south; 200-bed hospital with addition of 100-beds under construction located in college town of about 25,000. (MH-3533) (f) Purchasing agent; department head level; east; 300-bed hospital. (MH-3547) (g) Personnel director; south; man or woman; 375-bed teaching hospital unit of University Medical Center. (MH-3565).

SHAY—*Continued*

MEDICAL RECORD LIBRARIANS (a) Chief; south; University Hospital located in beautiful university community; require 2 years experience (MH-3615) (b) Chief; California; 120-bed hospital; 3 well qualified assistants; standard nomenclature of disease and operations is used and a visible file is used in indexing; $6000. (MH-3212) (c) Chief; middle west; suburb of Chicago; 160-bed hospital; $6000 up. (MH-3416).

DIETITIANS (a) Chief; Florida; 250-bed hospital; few minutes from ocean; Facilities complete and modern; $4800 up. (MH-3414) (b) Administrative; middle west; 400-bed hospital; dietary department new and well equipped; $5400. (M-3560) (c) Chief; east; 380-bed hospital near New York City, to $6500. (MH-3571) (d) Chief; south; 500 bed teaching hospital; 3 kitchens well equipped; 9 dietitians plus other well qualified workers in department, to $6720. (MH-3331). (e) Senior dietitian; Pacific Northwest; responsible for operation of all phases of centralized patient care in new 320 bed teaching and research hospital; $6500 (MH-3593).

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PLACEMENT BUREAUS

A & G MEDICAL PERSONNEL AGENCY
834 Second Street
Lancaster, Pennsylvania

In addition to the positions listed under Positions Open, we have an impressive list of attractive offers under the following Classifications. They represent hospitals and communities of various sizes and locations, therefore we can assist you to secure the type of position you prefer. Write for details. All inquiries confidential. NO REGISTRATION FEE.

Administrators — Anesthetists — Anesthesiologists — Dietitians — A.D.A. & Therapeutic; Executive Housekeepers — Male and Female; Medical Record Librarians — Pharmacists — Physical Therapists — Physicians & Surgeons — House Physicians — Pathologists — Radiologists.

NURSES—Director of Nurses (includes female & male); Assistant Director of Nurses, Director of Nursing Administration, Assistant Director of Nursing Service, Medical Supervisors, Surgical Supervisors, O.R. Nurses, O.R. Supervisors, Supervisors of O.R. Nursing, Head Nurse Medical Unit, Head Nurse Pediatric Unit, O.B. Supervisors, Staff Nurses all shifts, Surgical Technicians & School Nurse.

A & G MEDICAL—*Continued*

FACULTY positions include Education Directors, Associate Director of Nursing Education, Assistant Director School of Nursing, Clinical Instructors — Medical, Surgical, Nursing Arts, OB, Fundamentals of Nursing, Pediatric Nursing, etc.

LABORATORY TECHNICIANS & TECHNOLOGISTS — X-RAY TECHNICIANS — Vacancies for male and female technicians. Salaries in most instances are open and depend on qualifications and experience of the individual. Others are quoted as salary, plus perquisites, plus living accommodations.

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INDIANA MEDICAL BUREAU
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Indianapolis 4, Ind.

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

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FURNITURE REFINISHING

Quality Work — Guaranteed

Metal or wood furniture refinished to a like new condition at your hospital. Anywhere in the Southern Hospital District.

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1700 Llanfair Ave., Cincinnati 24, Ohio

SCHOOL—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in obstetric nursing to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

(Continued on page 174)

classified advertising

SCHOOL—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all techniques in inhalation, intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write School for Nurse Anesthetists, University Hospital, Ann Arbor, Michigan.

ST. MARY'S HOSPITAL, Minneapolis, Minnesota, offers a fifteen month course in anesthesiology to graduates (men or women) of accredited schools of nursing. The course includes theory and experience in all phases of modern anesthesia. Enrollment dates February, May, August and November. Direct Correspondence to Director, Department of Anesthesia.

BARNES HOSPITAL: Offers an 18 month post-graduate course in Anesthesia to registered graduate nurses. Theoretical requirements of the American Association of Nurse Anesthetists met. Miss Helen Vos, R.N., B.S., Educational Director. Clinical training includes all techniques and procedures, Stipend provided. For information, write Mrs. Dean Hayden, Director, School of Anesthesia, Barnes Hospital, St. Louis 10, Missouri.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, $100.00 approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis 10, Missouri.

"ANESTHESIA SCHOOL FOR NURSES, St. Joseph's Hospital, Lancaster, Pennsylvania, 18 month course AANA approved. No tuition. Stipend. Large clinical experience for students including great many endotracheal intubations. For complete details write Dr. N. Kornfield, St. Joseph's Hospital, Lancaster, Pennsylvania."

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of $75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-in Hospital, Providence 8, Rhode Island.

presenting **Vina-Lux® 800 Series**

HEAVY-DUTY ARCHITECTURAL PATTERNS

the new vinyl-asbestos tile with color-chip styling throughout the thickness of the tile — at no extra cost!

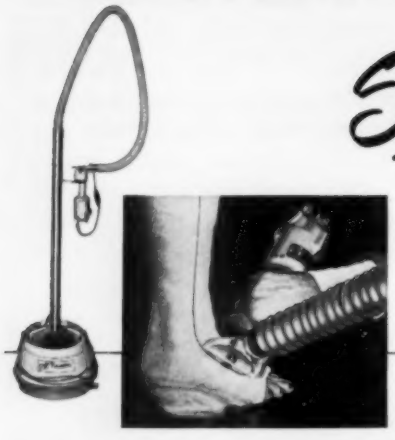
PERMANENT BEAUTY — EVEN IN PROBLEM FLOOR AREAS! Vina-Lux 800 Series is the ideal answer to the constant wear and tear of heavy foot traffic because the color chips are distributed throughout the full thickness of the tile — from top to bottom. It combines artistic beauty with rugged durability.

LONGER WEAR—LOWER MAINTENANCE COST! Vina-Lux 800 Series is denser, more closely textured, more resilient. Superior construction resists indentation, dirt and grime, is unaffected by grease, alkali and common chemicals — gives a new degree of comfort and safety underfoot.

SIX DISTINCTIVE COLORS! Vina-Lux 800 Series offers a distinctive selection of decorative colors — including beiges, greys, green and white — that solve the most exacting requirements in decor and light reflectance.

COSTS NO MORE! Despite its many new features and outstanding advantages the Vina-Lux 800 Series costs no more than ordinary vinyl asbestos tile. Complete information, samples and color charts are yours without obligation.

AZROCK FLOOR PRODUCTS DIVISION
UVALDE ROCK ASPHALT CO. • 511 FROST BANK BLDG. • SAN ANTONIO, TEX.



Today's concept in cast removal . . .

Stryker CAST CUTTER with PLASTERVAC

The Stryker Cast Cutter is universally accepted today as the most modern method for quick safe cast removal. The PlasterVac, when attached to the Cast Cutter, instantly picks up all dust and dirt as the cast is cut.

Write for additional information today.

SURGICAL AND HOSPITAL EQUIPMENT

Stryker Orthopedic Frame Company

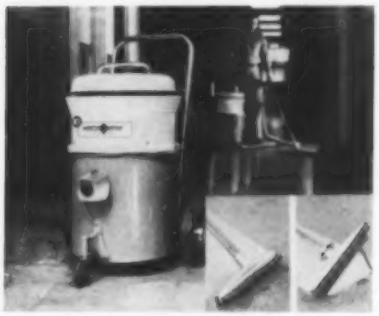
420 ALCOTT STREET • KALAMAZOO, MICHIGAN

WHAT'S NEW

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form on page 195. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

Operating Room Cleaned With Microstat Dual-Purpose Tool

A dual-purpose cleaning tool for the operating room is now available to increase the efficiency of the Microstat vacuum

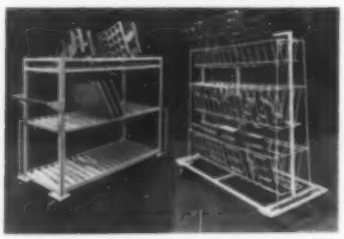


cleaner. Developed to help meet the problem of control of "staph," the Microstat has an impaction filter which traps practically all bacteria and the exhaust air is gently diffused to eliminate turbulence and the resulting dust movement. The new suction tool can be used for both wet pick-up and spot scrubbing for removing caked blood and other stains on the operating room floor after it is flooded with a germicide solution for cleaning between operations. The tool is quickly switched from wet pick-up (pictured at left) to the scrubbing position when the attendant rotates the handle to stand the tool on its end and follows by downward pressure on the handle to bring the brush into position. With the new auxiliary tool the Microstat becomes an all-around floor cleaning machine with the added benefit of bacteria control. **The Kent Co., Inc., Rome, N.Y.**

For more details circle #758 on mailing card.

Pan and Tray Racks Facilitate Washing

Washing of pans, trays and utensils is facilitated with two new improved pan racks introduced by Alvey-Ferguson. A-F Model B-187 shown on the left in the illustration is a "Shelf-Type" Pan Rack with three wide shelves and bumper style han-



dle. Model B-191 on the right is an "Assorted" Pan Rack with three continuous pockets on each side for holding all types of pans to expose all sides to high pressure spray for washing and sanitizing. Both racks are easily wheeled to destination for loading and unloading and slide into the washing machines. **The Alvey-Ferguson Co., 5962 Disney St., Cincinnati 9, Ohio.**

For more details circle #759 on mailing card.

Curity Cover Sponge for Narrow Wounds

Developed to eliminate waste of wide dressings where they are not actually needed, the new Curity 4 by 3 Cover Sponge for narrow type surgical and other wounds, folds out to a functional 3 by 8 shape. Offered in the Curity S.E. Pack which is sterile and easily opened by peeling back the flap, the new Cover Sponge is packed in a small, convenient tray, ready for use. **Bauer & Black, Div. The Kendall Co., 309 W. Jackson Blvd., Chicago 6.**

For more details circle #760 on mailing card.

X-Ray Images Transmitted by Closed-Circuit Television

Medical TVX is the name given to a new system which permits the transmission of actual x-ray images by closed circuit television. New, advanced closed-circuit television equipment developed for this purpose employs an image converter tube in which the x-ray image is converted directly to a form available for amplification. The resultant signal is amplified and presented

for viewing on a regular kinescope. TVX requires considerably less radiation dose than in fluoroscopy, thus protecting the patient. By placing two TVX systems 90 degrees apart, two simultaneous views can be obtained for special studies. **General Electric X-Ray Corp., 4855 W. Electric Ave., Milwaukee 14, Wis.**

For more details circle #761 on mailing card.

(continued on page 178)

For additional information, use postcard facing Cover 3.

Dish and Tray Trucks Speed Collection of Dishes

Soiled dishes, silverware, trays and other food service utensils are quickly removed with the help of the new Ideal dish and tray trucks. The sturdy units are built for steady use, mounted on six-inch casters, two swivel and two rigid for maneuverability, and move silently and easily even when heavily loaded. Truck shelves are of 18-gauge stainless steel with raised edges to protect contents. The tubular U-shaped frame and V-nose construction give strength and facilitate cleaning. Dish trucks are available in two and three-shelf models, and tray trucks in four and five-shelf models. **Swartzbaugh Mfg. Co., Murfreesboro, Tenn.**

For more details circle #762 on mailing card.

Flo-Matic Photocopier Features Pushbutton Filling

The new Cormac Golden Corvette photocopy machine facilitates the making of photocopies and eliminates waste and spoilage of processing solutions due to evaporation and oxidation. The "Flo-Matic Control" instantly fills or empties the photocopier tray at the touch of a button. When not in use, the processing solution is electrically removed to a concealed dispenser so that the developer will last up to a month, depending on the volume of copies produced. **Cormac Photocopy Corp., 80 Fifth Ave., New York 11.**

For more details circle #763 on mailing card.

Redesigned Trapeze Bar Serves as Patient Aid

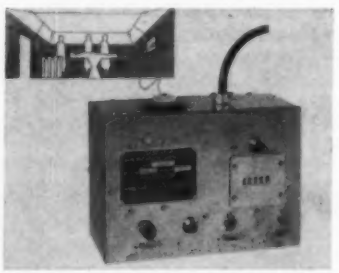
An exclusive pivoting feature that permits the entire bar to be swung off at a

45-degree angle, makes the newly redesigned Simmons Trapeze Bar serve a double purpose. In addition to orthopedic uses, the bar can thus serve as an aid in helping patients get in and out of bed. It is easily installed on all standard 3/0 hospital beds and adjusts to fit the height of the head end panel. The Plastisol covered Trapeze Bar hangs on a link chain, making it adjustable to the most desirable height. When not in use the Trapeze swings completely out of the way. **Simmons Co., Merchandise Mart, Chicago 54.**

For more details circle #764 on mailing card.

Precision Instrument Warns of Static Electricity

The presence of static electricity in the operating room or other danger area is quickly detected by the new electronic device called a Staticator. Developed to help hospitals maintain recommended safe practices for operating rooms, the Staticator includes a small wall-mounted control box connected to an antenna which is sus-



pended from the walls above the heads of persons in the room. It will instantly detect any increase in the static charge, either positive or negative, and gives both an audible buzzer and a visible light warning. A counter incorporated in the Staticator gives a record of the number of violations to help in maintaining control. **National Cylinder Gas, Div. of Chemetron Corp., 840 N. Michigan Ave., Chicago 11.**

For more details circle #765 on mailing card.

(continued on page 180)

A-777

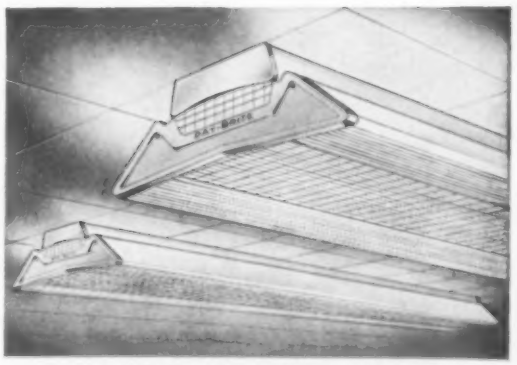
EVER LOOK AT RELIGHTING THIS WAY?

The unusual perspective shown above illustrates this point: To get the most from each square foot of *floor* space, make the most of *ceiling* space. And the hardest working ceilings are planned around Day-Brite "Full Comfort" lighting.

This is particularly true in the modernization of offices, plants and stores. Nearly always, the easiest and most effective way to increase productivity is by relighting with Day-Brite equipment. In the complete Day-Brite line, you'll find fixtures that solve problems caused by structural or budget limitations — fixtures delivering highest illumination efficiency without sacrificing appearance. To make sure *your* clients get the most from their ceilings, consult your Day-Brite representative. He's listed in the Yellow Pages. *Day-Brite Lighting, Inc., St. Louis 15, Missouri and Santa Clara, California.*

DAY-BRITE

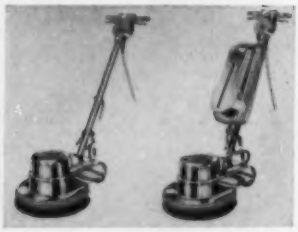
When you get down to "ceiling plans" call Day-Brite



DAY-BRITE'S NEW FAIRVIEW

For offices, stores and schools. 8 feet of Day-Brite quality and performance at half the price you'd expect to pay! Features the first full 8-foot prismatic enclosure. Low-brightness CLEARTEX® panel of X-5 plastic (guaranteed not to discolor for 5 years). Translucent sides for soft ceiling lighting. Designed for easy installation, speedy servicing.

Floor Maintainer Line Has Totally Enclosed Motor

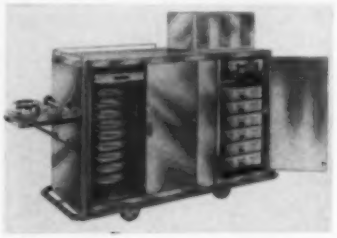


A totally enclosed motor, designed especially for the new line of Clarke floor maintainers, drives the brush at a rated speed on any 15 amp. circuit, even when steel wooling wet floor seal or when disc sanding. The new machines are designed to perform a wide range of floor cleaning and renovating jobs and are available with brush diameters of 14, 15, 17 and 20 inches, with motors of corresponding size, for use on any type of floor. **Clarke Floor Machine Co., Muskegon, Mich.**

For more details circle #766 on mailing card.

Hot and Cold Foodveyor for Beverages and Foods

Two features of the new Blickman RB-LG Hot and Cold Foodveyor eliminate the necessity of pouring cold beverages when serving, and of "swabbing" the dispenser well. Forty-eight beverage glasses can be filled in the central kitchen and delivered upright and cold to the patient floor in the roll-away drawer which is easily removed for cleaning in the dishwasher. Portion control is assured and time is saved. The coffee dispensers in the drawer of the hot compartment facilitate pouring coffee and are removed when the drawer is cleaned. Uniform heating is provided by a radiant element on bottom and sides of the heated compartment and a commercial ¾ h.p. compressor ensures fast



cooling of the entire cold compartment. Both compartments have removable interiors for easy cleaning. **S. Blickman, Inc., 8400 Gregory Ave., Weehawken, N.J.**

For more details circle #767 on mailing card.

Can Washer and Drain for Food Service Department

Designed for installation in food service departments where high standards of sanitation are essential, the new Josam Series No. 5380 Can Washer and Drain washes cans and collects refuse from the waste water. It consists of a cast iron floor drain with double drainage flange, heavy grate with substantial free area, removable bronze perforated sediment basket and interior piping with a jet spray nozzle designed for trouble-free operation. **Josam Mfg. Co., Dept. X-38, Michigan City, Ind.**

For more details circle #768 on mailing card.

Anesthesia Ventimeter Monitors Patient Ventilation

The Roswell Park Ventimeter is an anesthesia machine accessory to indicate tidal volume. When mounted near the anesthesiologist, it may be seen from practically any place in the operating room and provides direct and continuous visual in-

dication of tidal exchange. The Ventimeter design utilizes a volume-indicating bellows with the familiar breathing bag and pressures are indicated on an aneroid manometer. In addition to its basic use, the new Ventimeter is a convenient teaching accessory, a check for the anesthesiologist and members of the operating team, and provides a check for the sensitivity of mechanical assistors and flowmeter assembly. **Air-Shields, Inc., Hatboro, Pa.**

For more details circle #769 on mailing card.

(Continued on page 182)

Housekeepers Love Mr. Clean

because he's Procter & Gamble's all-time cleaning champ. Mr. Clean does more cleaning . . . faster and easier than any other type of cleanser, soap or detergent your staff has ever used.

He's a work-saver, time-saver and mighty handy guy to have around. He's Mr. Clean, Procter & Gamble's all-purpose cleaner. Wherever he goes—and that can be almost everywhere—Mr. Clean gets the cleaning job done faster, easier than any other type of cleaning product.

Bathrooms, kitchens, utility rooms . . . why, he just zooms right through and leaves 'em sparkling clean. Lobbies, hallways, stairways . . . you'll be amazed at Mr. Clean's speed. Used right from the bottle or diluted in a pail or wash basin, Mr. Clean will quickly make light work out of the heaviest cleaning chore. Saves time too, for many jobs require no rinsing.

And because of Mr. Clean's easy-to-handle bottle, your cleaning personnel can take him along everywhere . . . no need to transfer from large bulky containers . . . no need to guess at amounts. Directions are on every bottle.

Yes, he's the all-time champ at all kinds of cleaning! Meet Mr. Clean himself!

Look! Mr. Clean will clean everything you see here!

grime from fountains . . . footmarks on stairways . . . grease from ranges . . . hand marks on doors and walls . . . sediment in sinks!

Arm Sling Suspension
Fits Tubular Wheelchair

Any tubular wheelchair can be fitted with the new Arm Sling Suspension unit

by attaching the quickly installed bracket. The overhead support rod moves out of the way when the sling is not in use and the assembly is adjustable to any position along the overhead stainless steel rod. The comfortable leatherette sling can be adjusted for use by any patient, child or adult. It gives excellent arm support for self-feeding, exercising and other purposes. **Rehabilitation Products, Div. of American Hospital Supply Corp., Evanston, Ill.**

For more details circle #770 on mailing card.

Poli-Seal Floor Finish
Seals and Polishes

Only one operation is required to seal and polish floors with the new finish known as Poli-Seal. It is designed for use on light terrazzo, white cement, magnesite, white marble, cork, wood, ceramic tile, quarry tile and slate floors and may also be used on many vinyls and linoleums. It provides a water-white finish that will not darken floors, is water-resistant and deters efflorescence of hard floors. **Huntington Laboratories, Inc., Huntington, Ind.**

For more details circle #771 on mailing card.

Portable Microfilmer
Weighs Only 24 Pounds

Designed to be carried from place to place where it is needed, the new Recordak Portable Microfilmer weighs only 24 pounds. It has all of the features built into the larger microfilmers, with film units

removable and interchangeable. Two rolls of film may be exposed simultaneously and the film unit has a capacity of 100 feet. Documents 12 inches wide, of any length, may be photographed in sequence. **Recordak, 415 Madison Ave., New York 17.**

For more details circle #772 on mailing card.

"Orthomatic" Sterilizer
Has Automatic Pushbutton Control

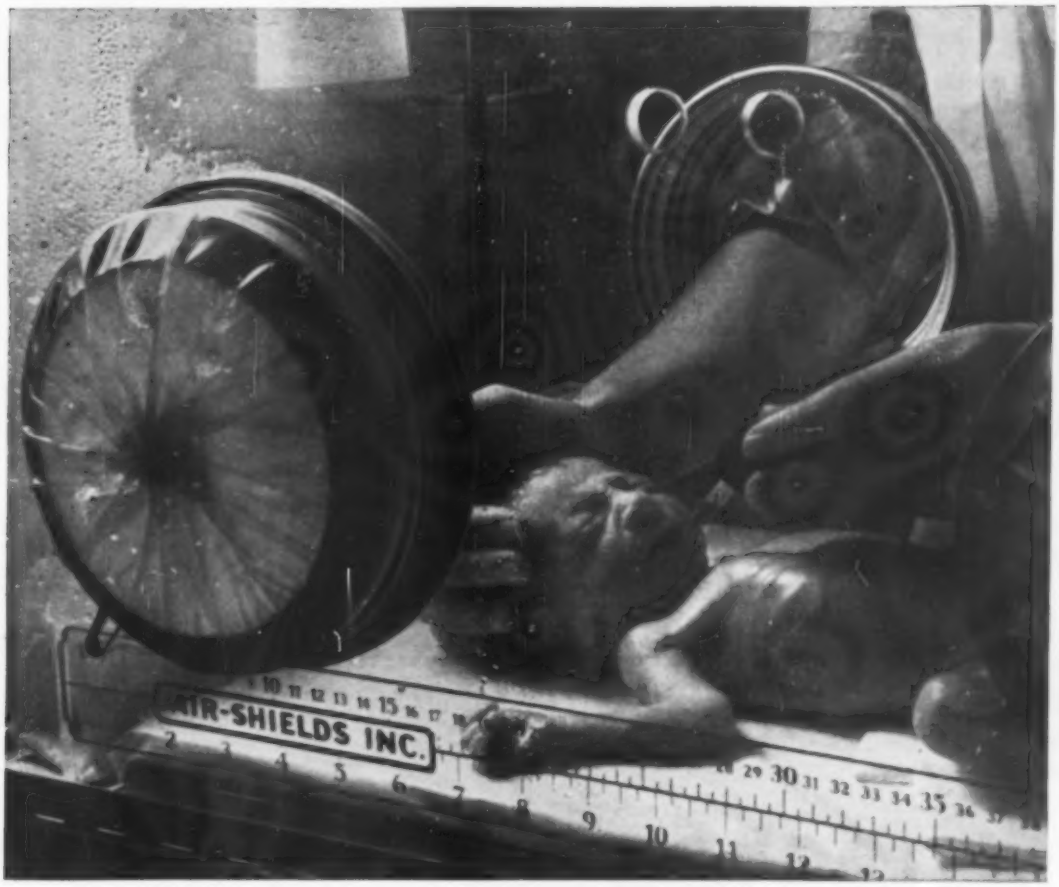
Reduced cycle time and completely automatic, pushbutton control are features

of the new Castle Orthomatic Sterilizer. The Orthomatic replaces conventional multiple dials, handles and switches with four easly identified keyboard controls marked: Liquids, Dry Goods, Manual, and Steam Off. When the proper key is pressed, the desired sterilizing cycle is started and all subsequent phases follow automatically with a buzzer indicating cycle completion. A permanent record of temperature and pressure for each sterilizing cycle is furnished by the indicating controls. Cycle temperature can be varied by turning a calibrated dial and the Orthomatic can take all loads. **Wilmot Castle Co., 1939 E. Henrietta Rd., Rochester, N.Y.**

For more details circle #773 on mailing card.

(Continued on page 184)

Greater promise for survival within the "protective shell" of the ISOLETTE®



The ISOLETTE® insures every advantage for survival.

Maximum protection for the tiniest infant requires strict isolation and precise control of the incubator environment. The ISOLETTE® Infant Incubator alone provides these essentials through "well regulated warmth and humidity and economical oxygen concentrations in a convenient working area for nurse and doctor . . . The isolation of the patient from his neighbors and from the contaminated or ailing doctor or nurse is an additional safeguard. Intravenous cutdowns, weighings, spinal taps and other procedures are all possible within its protective shell."[1]

For absolute isolation, fresh, pathogen-free, circulating outside air is made available only by the ISOLETTE. When nursery air must be used, addition of the new MICRO-FILTER to the ISOLETTE incubator provides pathogen-filtered air by removing all air-borne contaminants down to 0.5 micron in size. Moreover, ". . . a humidity of 80 to 90 percent can be obtained only in incubators with forced ventilation (e. g., the ISOLETTE)."[2]

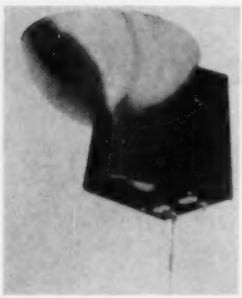
For additional information about the ISOLETTE, write to AIR-SHIELDS, INC., Hatboro, Pa. or phone us collect from any point in the U.S.A. (OSborne 5-5200).

1. Lynn, H.B.: Postgrad. Med., 22:429, 1957.
2. Dancis, J.: Postgrad. Med., 22:194, 1957.

AIR-SHIELDS, INC.

Hatboro, Pa., U.S.A.

Research and engineering to serve medicine throughout the world.



Hospitality Wall Bracket Is Functional and Decorative

All electrical functions are combined in one compact, inexpensive unit in the new Versen Model #9320 overbed Hospitality Wall Bracket. In addition to providing general room illumination and a reading light, the wall bracket fixture has convenience outlets and a night light. It is practically maintenance-free since there are no moving parts, and the design makes it a decorative addition to any room. **Kurt Versen Incorporated, Englewood, N.J.**

For more details circle #774 on mailing card.

China-Cote Cups for Vending Machines

Two new hot drink cups manufactured in a new lighter-weight, economy-priced China-Cote are now offered for use in vending machines. Both cups are in the seven-ounce hot drink vending size in the squat shape (C7WL6V) and the tall shape (C7RL6V). The standard Lily heavy-weight China-Cote hot drink vending cups are still available in the seven and nine-ounce squat shape sizes for vending use. **Lily-Tulip Cup Corp., 122 E. 42nd St., New York 17.**

For more details circle #775 on mailing card.

Relax "Angle" Design Bedpan Now in Stainless Steel

The Jones "angle" design bedpan is now available in stainless steel for greater sanitation and ease of cleaning. The "Relax" design is easier to administer and the thin, tapered back edge lets the patient rest

comfortably while the contour of the bedpan fits the buttocks and accommodates the coccyx without uncomfortable pressure against the metal. The bedpan can be slid into place without moving the patient and the angle design and rounded edges make it easy to use for patients who are helpless and must be rolled onto it. **The Jones Metal Products Co., West Lafayette, Ohio.**

For more details circle #776 on mailing card.

Speedscrub Floor Scrubber Conforms to Surface Irregularities

A multi-sectioned brush, designed to conform automatically to surface irregularities, is a feature of the new Speedscrub Floor Scrubber. The bristles are woven on to the all metal back by wire and the longer outer bristles assure all bristles maintaining contact with the floor under extra pressure. Brush and motor are one unit

which is mounted on an "A" frame that is raised or lowered with one central control, permitting variable brush pressure control. Speedscrub will efficiently scrub or strip surfaces such as composition tile, ceramic tile, wood or cement. The brush will raise to clear door jambs and will extend under kickboards. The motor is electrically reversible, water flow is adjustable and the tank has a capacity of 10 gallons. **Nobles Engineering & Mfg. Co., 645 E. 7th St., St. Paul 6, Minn.**

For more details circle #777 on mailing card.

(Continued on page 186)

Unbreakable Jars on Septisol Soap Dispensers

Unbreakable linear polyethylene jars are now used instead of glass on the new metal Septisol Soap Dispensers. The translucent jars, which show the amount of soap at a glance, are 42-ounce capacity and may be boiled or autoclaved. **Vestal Inc., 4963 Manchester Ave., St. Louis 10, Mo.**

For more details circle #778 on mailing card.

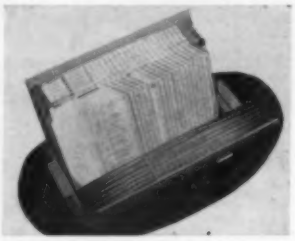
Adhesive Traction Band Simplifies Traction

Super-Trac is an adhesive traction band which can be applied directly to the skin of a fractured limb and stays in place because of the adhesive backing. The new polyurethane foam of Super-Trac molds itself to the contours, conforming to any depressions or protrusions. It is hypo allergenic and eliminates the need for excessive bandages in applying traction. **The Scholl Mfg. Co., Inc., 213 Schiller, Chicago 10.**

For more details circle #779 on mailing card.

Appointment Schedule for Clinic Doctors

Efficiency is improved and time saved in scheduling and handling appointments for doctors in out-patient and other clinics with the Veri-Visible Appointment Scheduling system. "Duplicate posting" furnishes an accurate copy of the original card automatically, speeding paperwork and reducing clerical errors. The card form lists all patients with appointments throughout the day with full details. The duplicate copy is sent to the medical record depart-



ment, then to the doctor's desk with case histories attached, and finally to the bookkeeping department with the doctor's note on charges. **Acme Visible Records, Inc., Crozet, Va.**

For more details circle #780 on mailing card.

Emergency Generating Set Takes Over Automatically

The new Uninterrupted Power Supply emergency generating set is designed to correct a power failure so quickly that the discontinuity cannot be detected. The unit consists essentially of a synchronous dynamo, a flywheel, a magnetic clutch, a diesel engine and associated controls. When commercial power is restored, the controls automatically synchronize the generator set. **Consolidated Diesel Electric Corp., 880 Canal St., Stamford, Conn.**

For more details circle #781 on mailing card.

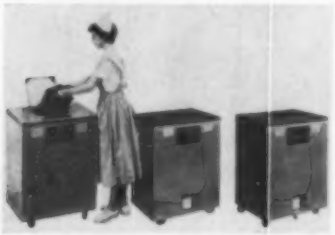
Easy-Tilt Bin Facilitates Waste Handling

Empty liquid cartons as well as other waste is handled with maximum sanitation and without heavy lifting or strain in the new Dawson Easy-Tilt Waste Bin. Liquids left in the cartons cannot leak out of the metal bin which is emptied by tilting on the mounting pivots where it may be held by a locking pin for complete and sanitary cleaning and rinsing. The easily maneuvered bin rolls on a dolly-like frame on rubber-tired, ball bearing casters and is available in two sizes. **Dawson Metal Co., Inc., 335 Harrison St., Jamestown, N. Y.**

For more details circle #782 on mailing card.

Rotary Machines for Surgical Glove Processing

Washing, drying and powdering of rubber surgical gloves is facilitated by use of three companion machines recently introduced. The unique tub design of the Rotary Washer keeps up to 150 gloves circulating freely beneath the surface of the water for washing and rinsing. The Rotary Glove Dryer has the same 150-glove capacity, is top loaded, and dries through warm air blown directly and continuously into the tumbling drum. The Rotary Pow-



derer processes 150 gloves in four to eight minutes, depending upon the coating: heavy, normal or light. Air-tight construction keeps powder from escaping and unused powder is recovered. Each machine has a flat 25 by 20-inch stainless steel top which can serve as a work surface, and swivel-type casters make them mobile. **Rotary Hospital Equipment Corp., 1746 Dale Rd., Buffalo 25, N.Y.**

For more details circle #783 on mailing card.

Increased Wet Capacity with Squee-zee 30

Made to be used with Models BP-2 and RS-1 Super Suction cleaners, the new Squee-zee 30 attachment increases the wet pick-up capacity to the maximum. The attachment consists of a 30-inch curved neoprene rubber blade mounted in a metal frame, a suction chamber, heavy duty hose, adjustable handle and plates for attaching to the transport handle of the cleaner. It is attached without the use of tools. The

Squee-zee is flexible and readily follows the contour of any floor. **The National Super Service Co., 1945 N. 12th St., Toledo 2, Ohio.**

For more details circle #784 on mailing card.

Medical Warning Stickers Mark Patient Charts

Red bordered, easily applied paper stickers, printed with medical warnings, are now available for application to patients' charts. The pressure-sensitive stickers are easily applied and the heavy red border and the wording, "Drug Sensitivity" in bold capital letters, alerts doctors and nurses to prevent errors. Space is provided for indicating the drug involved. **Topflight Corp., 160 E. Ninth Ave., York, Pa.**

For more details circle #785 on mailing card.

Sure Seal Nipple Prevents Leakage

The perfected Sure Seal rim around the nipple base of the new Twin Air Valve Nipple fits into the matching groove in the redesigned cap. As the cap tightens, it interlocks with the nipple to form a leakproof seal which helps prevent nipple pullout. The exact fit ensures maximum performance of the patented Twin Air Valves for perfect feeding action without excess air swallowing. The new feature is incorporated into all Evenflo nursing nipples,

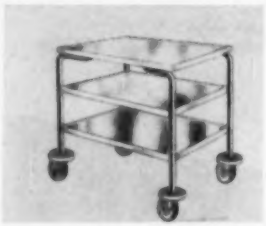
including the new Premie with the thin tip and the Lifetime Silicone Nipple. **Evenflo, Ravenna, Ohio.**

For more details circle #786 on mailing card.

(continued on page 188)

Utility Tables of Stainless Steel

Two and three-shelf tables constructed of stainless steel are now available in the Frick Dispensator Hospital Line. They come in a variety of sizes for every use, from 42 by 24 inches to 33 by 18 inches. The stainless steel tops have raised lip edges and legs are tubular chromium plated steel. Tables are mobile and have



wheel bumpers of non-marking rubber and ball bearing swivel casters with rubber tread tires. **W. H. Frick, Inc., 603 Citizens Bldg., Cleveland 14, Ohio.**

For more details circle #787 on mailing card.

Sanitizing Dustchek for Bacteriostatic Dust Control

A scientifically formulated, water soluble emulsion containing an integrated bactericide effective against staph and other organisms is available in Sanitizing Dustchek. The new product is designed to impregnate dusting equipment in bulk to keep bacteria from multiplying. Dust mops or cloths can be washed, rinsed and sanitized with Dustchek Type E dip treatment in the wash-wheel, immediately after the washing cycle. Properly treated dusting equipment, for floors, walls and furniture, wipes away germ laden dust for improved sanitation and easier cleaning. **Franklin Research, 5134 Lancaster Ave., Philadelphia 31, Pa.**

For more details circle #788 on mailing card.

Patient Room Light Mounts on Wall

Both direct and indirect lighting over the patient's bed is available with the new

Simes Bedroom Light. Designed especially for patient room use, the unit is mounted on the wall behind the bed with toggle bolts or other mounting devices. Either slimline or standard fluorescent lamps are installed in the troughs which are five or ten feet wide. An incandescent bed light with adjustable arm is mounted above the bed within reach of the patient and has an optional night light. **Simes Co., Inc., Dept. 14, 114-15 Fifteenth, College Point, N.Y.**

For more details circle #789 on mailing card.

(continued on page 190)

Paper Plate Dispenser Eliminates Fumbling

A paper plate dispenser, easily installed in a counter-top and available for both six

and nine-inch plates, eliminates fumbling and plate waste. It consists of a metal barrel with a spring mechanism that keeps pushing the plates to the top where a dispensing arm with a rubber suction cup picks up one plate at a time and lifts it from the stack. **Dixie Cup Co., 24th and Dixie Ave., Easton, Pa.**

For more details circle #790 on mailing card.

Wall-Mounted Dimmer for Variable Light Levels

Variable light levels for both fluorescent and incandescent lights can be achieved with fingertip control through the new Moe Light Dimmer. The wall-mounted unit provides infinite light control from brilliance to a dimmed glow. The unit is a transformer type switch and controls up to eight rapid-start 40-watt fluorescent lamps or eight trigger-start 20-watt fluorescent lamps, and any number of incandescent lamps up to a total load of 360 watts. **Moe Light Div., Thomas Industries Inc., 410 S. Third St., Louisville 2, Ky.**

For more details circle #791 on mailing card.

Futura Letter Box in Four Modular Sizes

Four modular sizes are available in the new line of letter boxes introduced for institutional use by Cutler. The Futura is built of polished satin finish aluminum, tailored on functional lines to blend with modern interiors. The four are designed to fit with each other in a panel, providing maximum flexibility. Keyed and combina-

tion security locking arrangements can be furnished with over 8000 possible combinations in the combination lock mechanisms. **Cutler Mail Chute Co., P.O. Box 1819, Rochester 7, N.Y.**

For more details circle #792 on mailing card.

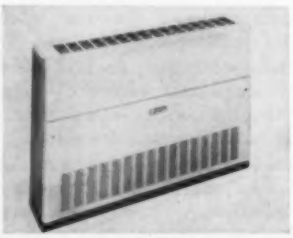
Sanitized Laundry Additive Retards Bacteria Development

The Sanitized chemical bacteriostat is now available in a laundry additive to retard the growth and development of bacteria, mold and mildew in clothing, linens, diapers and other fabrics. Sanitized L-50 is added to the wash after rinsing and treated laundry is said to inhibit the growth of bacteria indefinitely. **Sanitized Sales Co., 181 Madison Ave., New York 16.**

For more details circle #793 on mailing card.

Electric Cabinet Heaters for Maximum Flexibility

Maximum flexibility of arrangement and operation are assured with the newly designed Ilg electric cabinet heaters. Two



blow-through units with direct-drive fan assemblies and a draw-through model with V-belt-driven fan assembly are included in the new line. Units are available for floor, ceiling, wall or inverted mounting, non-recessed, semi-recessed or concealed. Three types of control available include manual, pneumatic and automatic and the contemporary design of the cabinets of formed furniture steel makes them suitable for use in any institution. **Ilg Electric Ventilating Co., 2850 N. Pulaski, Chicago 41.**

For more details circle #794 on mailing card.

Enamel and Tile Cleaner Is Gentle to Hands

Buckeye DYD is a pink cream cleaner for institutional use in cleaning porcelain, enamel and tile. The antiseptic cleaner leaves surfaces of bath tubs, refrigerators, stainless steel, chrome, brass and other materials clean and germ-free, yet the lanolin in the formula makes it safe and gentle to hands. **Davies-Young Soap Co., P.O. Box 995, Dayton 1, Ohio.**

For more details circle #795 on mailing card.

Laundry Brightener Whitens Without Bleach

Marlynbrite is the name of a new fabric brightener for use in the laundry which whitens without bleach. Added to the first suds, Marlynbrite restores the natural whiteness and color to garments and linens. It is instantly soluble, is harmless to fabrics, colors or human skin, and economical in use. **Marlyn Chemical Co., Inc., Lakeview, Ohio.**

For more details circle #796 on mailing card.

Pharmaceuticals

Tralcyon Filmtab

An anticholinergic with tranquilizer, Tralcyon Filmtab combines the potent, highly specific action of Tral, an anticholinergic, with the tranquilizing action of ectylurea for the management of gastrointestinal dysfunction aggravated by psychogenic factors. Each Filmtab contains 25 mg. of Tral and 300 mg. of ectylurea. It is indicated for the treatment of spastic or irritable colon, intestinal colic, hypermotility of the stomach or intestines and anxiety neuroses with vague gastrointestinal complaints. **Abbott Laboratories, North Chicago, Ill.**

For more details circle #797 on mailing card.

Synthetic Pencillin Tablet

The culmination of a ten-year research program, Syncillin is a synthetic penicillin in tablet form. It is the result of a complex chemical procedure for creating variations of penicillin and the synthetic penicillin compounds promise special disease-fighting advantages over existing antibiotics, according to the report. It is stated that preliminary tests indicate that Syncillin can provide effective antibiotic action in the bloodstream at levels twice as high as those obtained with the same dose of oral or injectable forms of the drug in its present form. Large scale trials of the new drug are planned to confirm early evidence that it will not produce the incidence of allergic reactions attributable to penicillin injections at present. **Bristol Laboratories, 630 Fifth Ave., New York 20.**

For more details circle #798 on mailing card.

A & D Ointment With Prednisolone

White's Viramin A & D Ointment is now available with Prednisolone 0.5%. It is an emollient, protective, healing ointment with the added benefits of anti-inflammatory, anti-allergic and anti-pruritic action for topical treatment of local inflammatory processes which arise with various types of dermatitis. It relieves itching and stimulates the formation of healthy granulation tissue. **White Laboratories, Inc., Kenilworth, N.J.**

For more details circle #799 on mailing card.

Terramycin Intramuscular Solution

A new formulation of Terramycin Intramuscular Solution is now offered for treatment of common infections caused by susceptible organisms. It contains oxytetracycline and the local anesthetic lidocaine in a stabilized liquid medium in parenteral form, requiring no reconstitution or dilution before administration. **Pfizer Laboratories, 630 Flushing Ave., Brooklyn 6, N.Y.**

For more details circle #800 on mailing card.

Midicel Acetyl Suspension

Midicel Acetyl Suspension is a butterscotch-flavored liquid sulfa compound effective against the same bacterial infections as the tablet form, with added values of ease of administration and acceptability in pediatric use. It is indicated for infections responsive to sulfonamide therapy, including respiratory infections, surgical and soft tissue infections and bacterial dysentery. **Parke-Davis & Co., Jos. Campau at River, Detroit 32, Mich.**

For more details circle #801 on mailing card.

Declomycin

Although related chemically to earlier tetracyclines, the new antibiotic, Declomycin, has increased antibiotic activity with less drug, greater stability in body media and 24 to 48-hour extra activity after discontinuance of dosage. It is indicated for treatment in infections caused by organisms sensitive to the tetracyclines. **Lederle Laboratories, Div. of American Cyanamid Co., Pearl River, N.Y.**

For more details circle #802 on mailing card.

(continued on page 192)

Literature and Services

• **Bulletin No. 1301B** describes the new Dunham-Bush unit heater line for steam and hot water heaters. Capacity data, conversion factors, basic formulas, piping arrangements and quietness levels are discussed and construction details and specifications for these heaters are given in the bulletin available from Dunham-Bush, Inc., West Hartford, Conn.

For more details circle #803 on mailing card.

• **The 1959-60 Reference Manual for Steel Equipment #487** is a 64-page guide available from Equipto, Aurora, Ill. Subjects covered include slotted angle, shelf filing, large drawer units, shelving, lockers and other storage equipment.

For more details circle #804 on mailing card.

• A comprehensive loose-leaf catalog, with sectional tabs for ready reference to the desired material, is offered by the **Despatch Oven Co.**, 619 Southeast Eighth St., Minneapolis 14, Minn. The full line of ovens for every need is illustrated and described with specifications, prices and accessories.

For more details circle #805 on mailing card.

• The complete line of Kinet-o-meters is illustrated, described and priced in the **"Heidbrink Anesthesia Apparatus and Accessories Catalog."** The 48-page catalog, available from Ohio Chemical & Surgical Equipment Co., 1400 E. Washington Ave., Madison 10, Wis., also describes accessories such as absorbers, vaporizers, rubber goods and endotracheal items.

For more details circle #806 on mailing card.

• Those concerned with food service in the hospital, as well as in the home and in public institutions, will find much helpful information in the 450-page compendium on nutrition offered by H. J. Heinz Co., P. O. Box 57, Pittsburgh 30, Pa. Written by the Heinz nutrition specialist, Dr. Benjamin Burton, with the assistance of an editorial board of six nutrition authorities, the **"Heinz Handbook of Nutrition"** is the first book-length scientific work to come out of the year-old Heinz Research Center.

For more details circle #807 on mailing card.

• Home economists, food technicians and professional writers collaborated in preparation of the new **General Foods Kitchen Cookbook** now available from General Foods, White Plains, N.Y. Designed to help in the planning, preparation and serving of complete meals, and arranged by meal situations, the 448-page book has full color illustrations and line drawings. Pages are grease-resistant, the cover is washable, and the book lies flat when open.

For more details circle #808 on mailing card.

• **"Scientific Floor Care"** is the subject of an eight-page manual developed by Multi-Clean Products, Inc., 2277 Ford Pkwy., St. Paul 16, Minn. Based on use of the right material, the right equipment with the right technic, the brochure describes machines and supplies, with full details, including data on the type of material for each job to be done.

For more details circle #809 on mailing card.

• Information on the complete **Portable Beauty Service** available to hospitals is available in a series of folders presenting the full story on the fully-mobile equipment and its use within the hospital. The effect of the service on the patients' morale is discussed and the special shampoo and other supplies are described. Full details of the **"Bedside Beauty Care"** are available from Hospital Beauty Service Systems, 625 Peach Orchard Ave., Dayton 9, Ohio.

For more details circle #810 on mailing card.

• Data on **Explosion-Proof Refrigerators** for use in hazardous locations, with a list of flammable or explosive materials, are presented in a folder available from the manufacturer of the safety-engineered units, Kelmore Service, Inc., 599 Springfield Ave., Newark 3, N.J. Specifications of Kelmore Explosion-Proof Refrigerators are included.

For more details circle #811 on mailing card.

• Information on **Designers mini-planner for "Food Facility Planning in Miniature"** is presented in a comprehensive form in an 8-page brochure available from Christine R. Pensinger Enterprises, 13551 Chandler Blvd., Van Nuys, Calif. Descriptive information with photographs of available templates, and data on kits for hospitals and other institutions are included.

For more details circle #812 on mailing card.

• **"Lightolier Lamps for Commercial Institutional Applications"** are illustrated and described in an eight-page brochure recently released by Lightolier, Inc., 346 Clarement Ave., Jersey City 5, N.J. Included are data on table, desk, wall and floor lamps and electrical columns.

For more details circle #813 on mailing card.

(continued on page 194)

• The Linde Oxygen Service for Hospitals includes liquid oxygen supply systems, delivery service, pipeline service and technical assistance. All phases of the **Linde Liquid Oxygen Supply System for Hospitals** are discussed in a new 12-page booklet available from Linde Company, Div. of Union Carbide Corp., 30 E. 42nd St., New York 17. Photographs and diagrams illustrate the equipment and its installation in a hospital.

For more details circle #814 on mailing card.

• Details concerning the odor-removing ability of activated charcoal in specific areas such as hospitals are discussed in an article, **"How Activated Charcoal 'Traps' Odors."** Written by a Consulting Engineer, the article describes the savings possible with activated charcoal through recirculation of warm or cool air. Copies of the article are available through the Barneby-Cheney Co., Cassady at 8th Ave., Columbus 19, Ohio.

For more details circle #815 on mailing card.

• An easy-to-use, plastic-bound catalog, which lies flat when open, illustrates and describes the various types of **Airmatic Tube Systems** available from Airmatic Systems Corp., an ITT Associate, 441 Market St., Saddle Brook, Rochelle Park, N.J. Illustrated with schematic layout drawings showing tube systems, photographs of equipment and of installations in use, and charts, the 52-page booklet tells how to select the right system for the need and describes operation, parts and installations.

For more details circle #816 on mailing card.

• More than 15,000 items available from American Hospital Supply Corp., 2020 Ridge Ave., Evanston, Ill. are listed in a new **825-page general catalog** recently released by that company. More than one-third of the items have been introduced within the past five years, and the catalog covers items from hospital beds to sutures.

For more details circle #817 on mailing card.

• **The Flexicore precast Concrete Floor and Roof System** is described and illustrated by photographs and detail drawings in the catalog available from The Flexicore Co., Inc., 1932 E. Monument Ave., Dayton 1, Ohio.

For more details circle #818 on mailing card.

• Characteristics of various types of fire extinguishers and a bar graph showing comparative effectiveness of extinguishing agents are included in **"A Guide To Fire Extinguishers"** published by Ansul Chemical Co., Fire Equipment Div., Marinette, Wis.

For more details circle #819 on mailing card.

Suppliers' News

Colonial Hospital Supply Co., handling furnishings, equipment and supplies for hospitals, as well as an efficient furniture-finishing service, announces removal of its plant and offices to a new address at **5115 Ravenswood Ave., Chicago 40.**

Groen Mfg. Co., manufacturer of food handling equipment, announces the removal of its plant and offices from Chicago to a new modern building at **1900 Pratt Blvd., Elk Grove Village, Ill.**

Gudebrod Bros. Silk Co., Inc., 225 W. 34th St., New York 1, manufacturer of non-absorbable surgical sutures, announces the opening of a new research and development, and control laboratory at its plant in Pottstown, Pa.

Lehn & Fink Products Corp., Professional Division, manufacturer and distributor of disinfectant and germicidal products for hospital sanitation, including Lysol, Amphyl, O-Syl, Tergisyl, and Instrument Germicide and Collatone Preservative, announces removal of its management and administrative staff from **New York City** to **4934 Lewis Ave., Toledo, Ohio**, as of **October 5.**

Miles Laboratories, Inc., Elkhart, Ind., manufacturer of drugs and fine chemicals, and of diagnostic products through its wholly-owned subsidiary, **Ames Company**, announces the acquisition of **Dome Chemicals**, producer of dermatological products for the medical profession. The new subsidiary will continue to operate in **New York City** at its present plant at **125 West End Avenue.**

Puremade Products, Inc., wholly-owned subsidiary of **Puritan Compresed Gas Corp., 2012 Grand Ave., Kansas City 8, Mo.**, announces full production in the first of its expanded new, highly automated N20 producing plants. The continuous-process, highly instrumented plant was inaugurated to augment the Puritan production facilities for Nitrous Oxide to meet the expanded demand in the field.

INDEX TO ADVERTISEMENTS

USE THIS PAGE TO REQUEST PRODUCT INFORMATION

The index on this and the following page lists advertisements in this magazine alphabetically by manufacturer. For additional information about any product or service advertised, circle the manufacturer's key number on the detachable postcard and mail it. No postage is required.

Products described in the "What's New" pages of this magazine also have key numbers which appear in each instance following the description of the item. For more information about these items, circle the appropriate numbers on the postcard and mail it, without postage, to The Modern Hospital.

(continued on next page)

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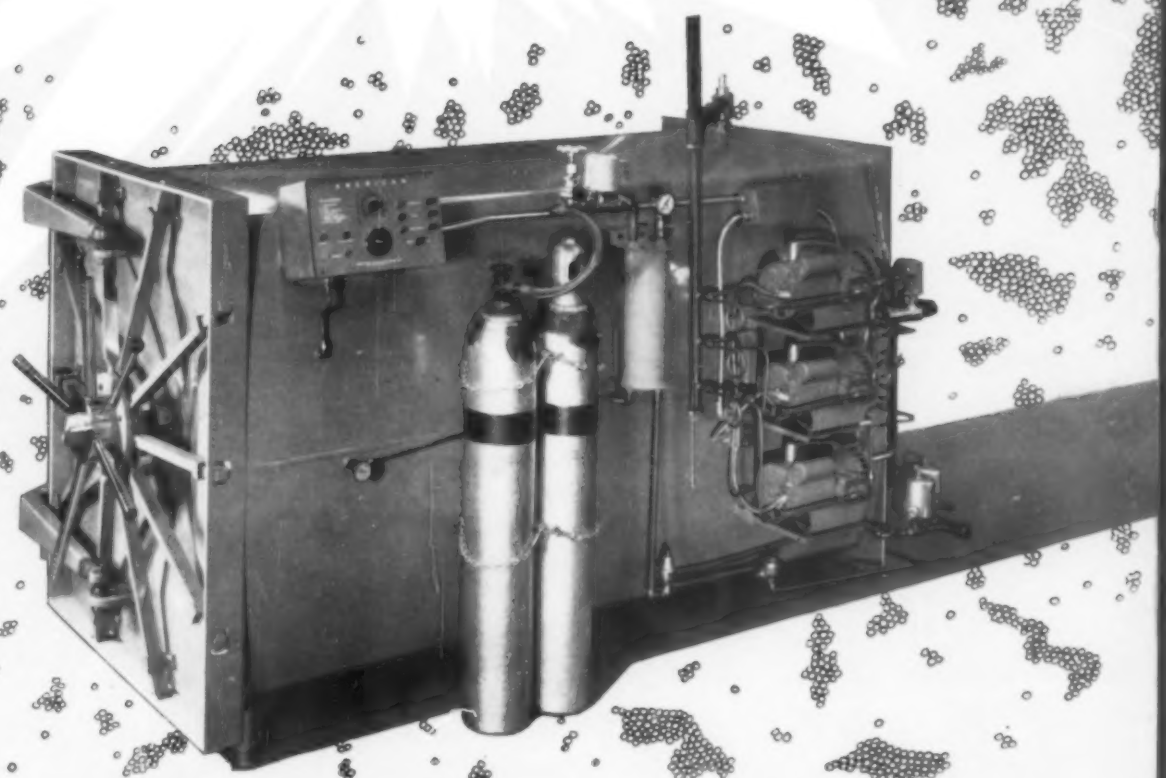

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MATTRESS *and* BEDDING DISINFECTOR *with special* LOADING CAR

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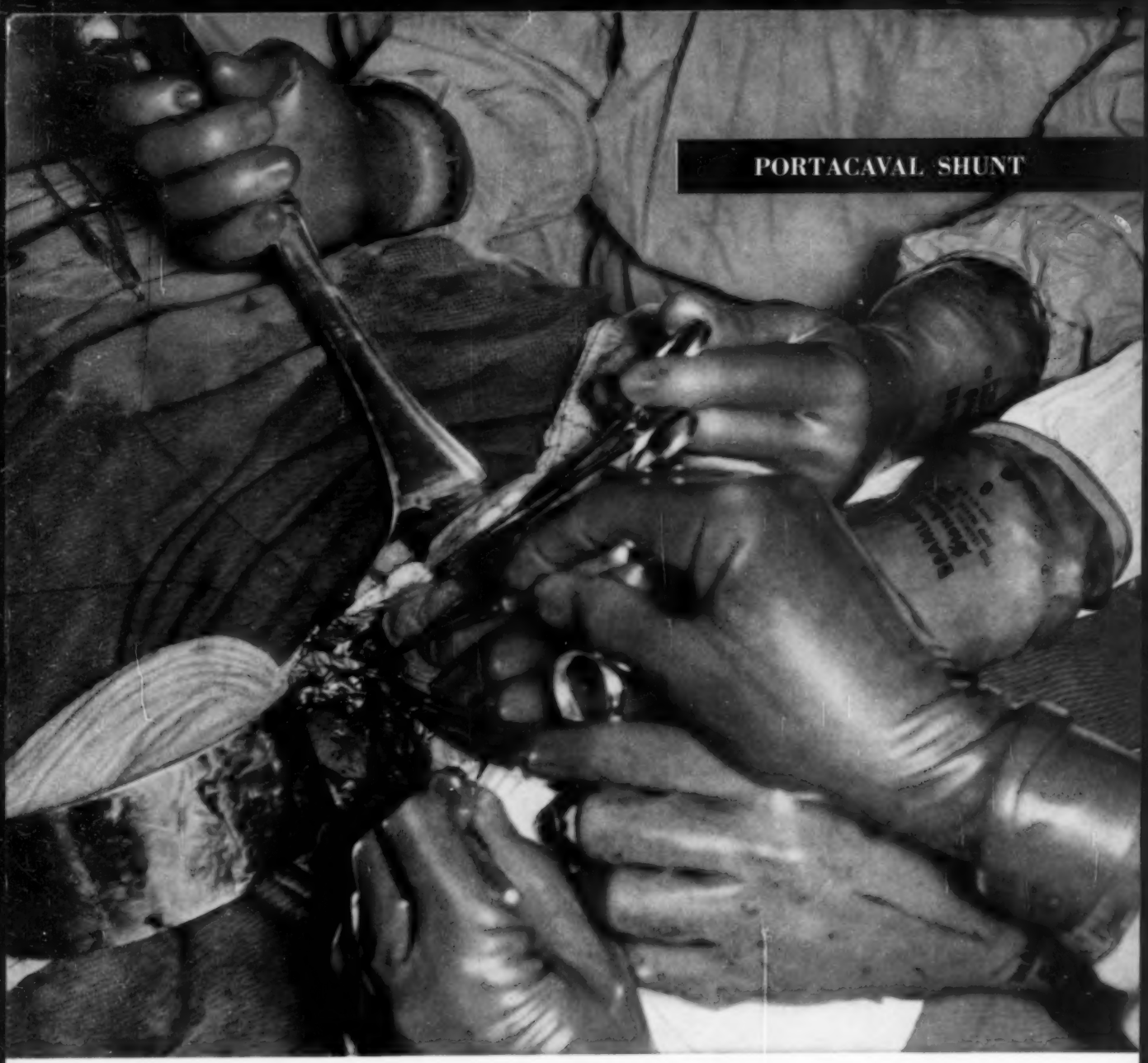

Make the Surgeon's Task Easier

Brown Milled Surgeons' Gloves by SEAMLESS

Before you order surgical gloves again, consider these facts. Deep in an incision, the maximum tactile sensitivity of Brown Milled Surgeons' Gloves by Seamless assure unmatched "sightless seeing." Minimal radial bind across the knuckles and palm guarantees maximum comfort. Equally important, their hypoallergenic property eliminates the possibility of latex dermatitis. These advantages make Brown Milled Gloves the finest general surgeon's glove available today. Contact your Seamless representative for further information and samples.

HOSPITAL DIVISION

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